



NOT TO CIRCULATE

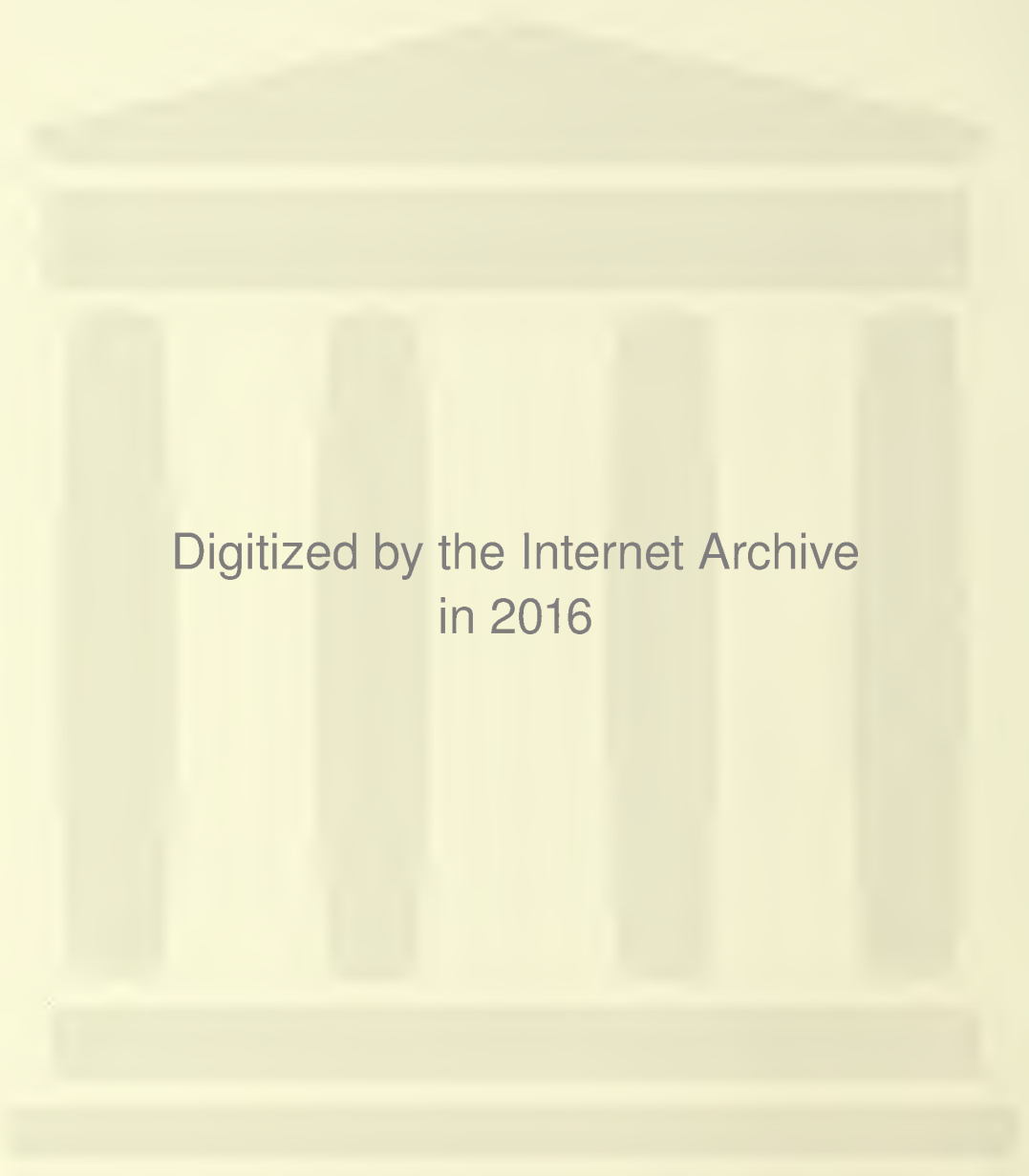


NOT TO CIRCULATE









Digitized by the Internet Archive  
in 2016

<https://archive.org/details/journalofarkansa9711arka>



# THE Journal

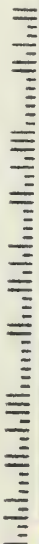
OF THE ARKANSAS MEDICAL SOCIETY

Vol. 97 No. 1

June 2000

\*\*\*\*\*MIXED ADC 010 553 P5

Health Sciences Library  
University of Maryland  
Acquisitions/Serials Dept.  
601 W LOMBARD ST  
BALTIMORE MD 21201-1512

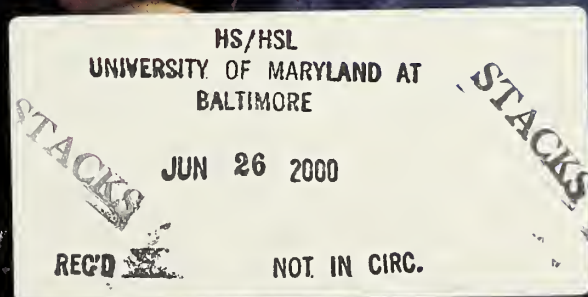


## We Poor Face Extreme Medical Needs

Arkansas Health Care Access Foundation  
Seeks Dedicated Doctors' Help

## Member Profile Miracle of Life Amazes Surgeon

Prenatal HIV Testing  
Reduces Transmission Risks



## To Do.

- Call the hospital
- Schedule nurse interview
- Order medical software
- Confirm on-call schedule

## Done.



The Most Complete  
Digital Service  
In Arkansas

Nationwide  
Wireless Coverage

A Name You  
Know And Trust

[www.swbellwireless.com](http://www.swbellwireless.com)

**Be more productive with the name you know  
and trust — Southwestern Bell.**

No matter how heavy your workload gets, Southwestern Bell Wireless can help lighten it. It just makes sense to stick with Southwestern Bell.

After all, who else would you trust to give you the technology that allows you to use your phone wherever and whenever? So before you make another "to do" list, pick up the tool that really gets things done — Southwestern Bell Wireless.



### SOUTHWESTERN BELL WIRELESS

#### EL DORADO

1801 North West Ave  
(870) 862-0010  
Mon-Fri 8:30 to 5:30  
Sat 10 to 3

#### FAYETTEVILLE

3075 N College Ave  
Fiesta Square  
Shopping Center  
(501) 444-9100  
Mon-Fri 8:30 to 5:30  
Sat 10 to 2

#### FORT SMITH

4300 Rogers Ave  
(501) 783-4600  
Mon-Fri 8:30 to 5:30  
Sat 10 to 2

#### JONESBORO

2801 S Caraway Rd  
(870) 935-5500  
Mon-Fri 8:30 to 5:30  
Sat 10 to 2

#### LITTLE ROCK

11520 Financial Center  
Parkway at Chenal  
(501) 225-2355  
Mon-Fri 8 to 6  
Sat 10 to 5

#### MONTICELLO

351-B Hwy 425 S  
(870) 460-9300  
Mon-Fri 8:30 to 5:30  
Sat 10 to 3

#### NORTH

#### LITTLE ROCK

2617 Lakewood  
Village Dr  
Lakewood Village  
Shopping Center  
(501) 812-7000  
Mon-Fri 8 to 6  
Sat 10 to 5

#### ROGERS

4404 W Walnut, Ste 1  
(501) 246-1000  
Mon-Fri 8:30 to 5:30  
Sat 10 to 2

#### RUSSELLVILLE

3065 E Main St  
Valley Park  
Shopping Center  
(501) 968-2464  
Mon-Fri 8:30 to 5:30  
Sat 10 to 2

#### SEARCY

2017 E Race  
Old Town  
Shopping Center  
(501) 279-0011  
Mon-Fri 8:30 to 5:30  
Sat 10 to 2

### WIRELESS EXPRESS STATEWIDE

Order by phone  
(888) 677-6701



Southwestern Bell reminds  
you to use your phone  
safely while driving.



{ PATIENT'S SMILE }

**YOU LOSE A LOT WHEN YOU LOSE YOUR SIGHT. PREVENT DIABETIC BLINDNESS.**

AFMC encourages Medicare and Medicaid providers to refer their diabetic patients to an eye care professional for an annual dilated eye exam. For more information on the AFMC Health Care Quality Improvement Program, call **1-877-650-AFMC.**



*Arkansas Foundation  
for Medical Care*

Now you can afford to have a mid-30's crisis.



It's the best preemptive strike on middle-age yet. With a 185 hp Kompressor engine, the C230 also comes standard with features like the Electronic Stability Program, regular scheduled maintenance\* and 24-hour Tele Aid\*\* assistance, making for one sweet ride at an incredibly attractive price. You'll feel younger and a heck of a lot wiser too. **The C-Class, starting at \$31,750.<sup>†</sup>**



Mercedes-Benz

Riverside Motors, Inc.

1403 Rebsamen Park Road, Little Rock, AR (501) 666-9457

†MSRP for a C230 Kompressor at \$31,750 excludes \$645 transportation charge, all taxes, title/documentary fees, registration, tags, retailer prep charges, insurance, optional equipment, certificate of compliance or noncompliance fees, and finance charges. Prices may vary by retailer. \*As called for by the Flexible Service System. Wear items excluded. Limitations apply. See your Mercedes center for a copy of the Mercedes-Benz limited warranty and details of The Mercedes Maintenance Commitment. \*\*Tele Aid requires consumer subscription for monitoring service, connection charge, and air time. Available only in cellular service areas. First year's monitoring, subscription, monthly access fees, and 30 minutes of air time included at no cost. See retailer for details. For more information, call 1-800-FOR-MERCEDES, or visit our Web site, [www.MBUSA.com](http://www.MBUSA.com). AIR BAGS ARE A SUPPLEMENTAL RESTRAINT SYSTEM, SO REMEMBER AIR BAG SAFETY: BUCKLE EVERYONE AND CHILDREN IN BACK! © 2000 Authorized Mercedes-Benz Retailers





# Submerging Technology: Hyperbaric Medicine

BY SAMUEL E. LANDRUM, MD, FACS

**F**or more than a century hyperbaric chambers have been in use for the treatment of divers suffering bends. (More than 100 were affected during construction of the Eads Bridge across the Mississippi River in St. Louis).

The benefit in this instance relates to compressing nitrogen bubbles. This same effect explains its use for arterial gas embolism. In the last half of the 20th century, it was found that oxygen, when administered at two or more atmospheric pressures, would dissolve in plasma in sufficient amounts to maintain vital functions thereby reviving the victim of carbon monoxide poisoning. Thus the hemoglobin bound by carbon monoxide was not required for oxygen transport.

Gas gangrene due to Clostridia is another highly lethal disease that is helped by hyperbaric oxygen treatment (HBOT). The alpha toxin of Clostridia is neutralized, and the progression of the systemic toxicity is halted. Aggressive debridement must be done, as well as antibiotic and supportive treatments.

During the more recent three decades it has been found that HBOT is of substantial adjunctive benefit in achieving healing in chronic wounds from arterial obstruction, mostly in the lower limbs. These wounds are encountered often by diabetic patients, especially those with neuropathy and impaired vascularity of their feet. Meticulous wound care, control of metabolic problems and infection, relief of pressure and shearing forces, and many other factors remain necessary components of the patient's care if success is to be achieved and sustained. For diabetics the rate of amputation or level of amputation is improved sevenfold when patients receive HBOT compared to those treated with local wound care alone.

Chronic refractory osteomyelitis is another indication for HBOT as an adjunct in the treatment. Improved function of leukocytes, neovascularity of the wound area and enhanced potency of aminoglycosides are some effects.

Some ill effects of radiation on bone and soft tissues are reduced by HBOT. Skin grafts or flaps that are failing are helped by HBOT, obviating the need for further grafting. Other uses are for patients with crush injuries and some burns. Other problems treated with HBOT, such as recluse spider bites and neurological diseases, are investigational and not widely recognized as appropriate indications.

During the first year of operation of a hyperbaric program at a regional medical center, more than 160 patients were evaluated for HBOT with 87 treated. Another 26 who were considered candidates could not undergo enough treatments to evaluate its effect; most of these patients had

claustrophobia or problems equalizing middle ear pressure well enough to permit pressurization within the chamber.

The results of those treated are summarized in the following table. Those benefited include patients whose amputation level was more distal than otherwise expected, patients who had grafts successfully cover a serious wound and patients who have not had enough treatments to achieve healing yet.

These patients were treated by accepted protocols for an average of 25 HBOTs, with a few healing quickly or

Diagnosis	Healed	Benefited	No Benefit
Arterial Obstruction, Lower Limb with Chronic Wound	24	23	13
Osteomyelitis	5	5	
Radionecrosis	4	2	
Failed Graft	3	3	1
Crush Injury		2	
Electrical Burn		1	
Fournier's Gangrene		1	

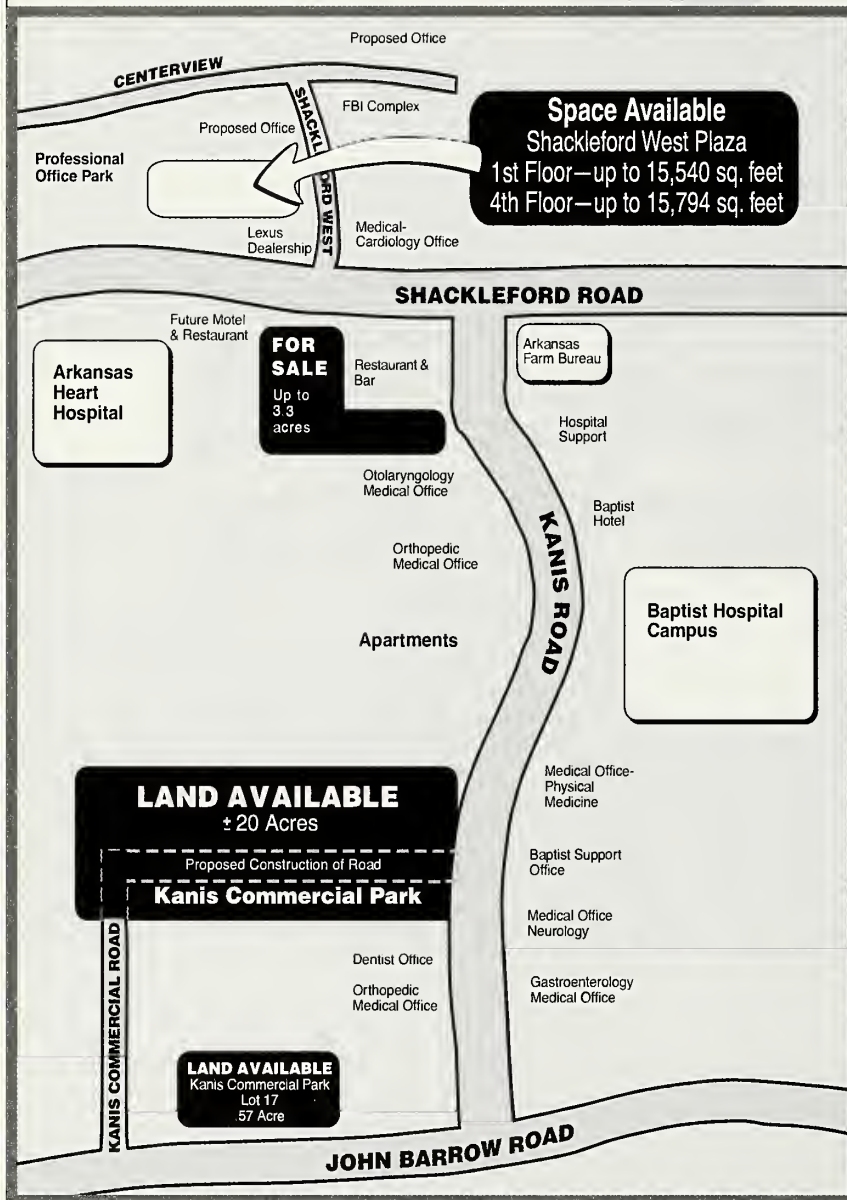
giving evidence of no benefit or receiving their definitive operation quickly, and several requiring treatments for eight to 20 weeks for optimum outcomes. This group includes people with multiple co-morbidities as evidenced by the fact that nine of these patients have died subsequently. Sixteen percent had no benefit, 42% healed and 42% were significantly helped by HBOT in the adjunctive treatment of wounds with healing problems with ordinary care.

This old treatment has not been widely applied. Its indications and appropriate uses are being recognized increasingly. With the population living longer — and especially with the high incidence of diabetes mellitus — the need for such therapy can be expected to increase to provide better care of patients with wounds that have defied our best efforts. ■

*Space is not available to discuss contra-indications and many details that are taught in a 60-hour course. These are just some highlights.*

*Dr. Samuel E. Landrum is a retired general surgeon from Fort Smith. Dr. Landrum is a member of the editorial board for The Journal of the Arkansas Medical Society.*

# Medical Community Land & Space Available



For information, please call:  
**Hank Kelley or Blake Lazenby at 501-375-3200**



**FLAKE & KELLEY**  
MANAGEMENT

TCBY Tower, Suite 300 • Little Rock, Arkansas 72201  
501-375-3200 • Telefax 501-374-9537  
[www.flake-kelley.com](http://www.flake-kelley.com)

COMMUNICATIONS COORDINATOR  
Judy Hicks

EXECUTIVE VICE PRESIDENT  
Kenneth LaMastus, CAE

ASSISTANT EXECUTIVE VICE PRESIDENT  
David Wroten

## EDITORIAL BOARD

Jerry Byrum, MD	Pediatrics
Joseph M. Beck, II, MD	Oncology
Lee Abel, MD	Internal Medicine
Samuel Landrum, MD	Surgery
Jerry Kendall, MD	Family Practice
William Ackerman, MD	Anesthesiology

EDITOR EMERITUS  
Alfred Kahn Jr., MD

## ARKANSAS MEDICAL SOCIETY 2000-2001 OFFICERS

Gerald A. Stolz, Jr., MD, Russellville  
*President*

Joe Stallings, MD, Jonesboro  
*President-elect*

Paul A. Wallick, MD, Monticello  
*Vice President*

Lloyd G. Langston, MD, Pine Bluff  
*Immediate Past President*

Carlton L. Chambers, III, MD, Harrison/Little Rock  
*Secretary*

Dwight M. Williams, MD, Paragould  
*Treasurer*

Anna Redman, MD, Pine Bluff  
*Speaker, House of Delegates*

Kevin Beavers, MD, Russellville  
*Vice Speaker, House of Delegates*

Joseph M. Beck, II, MD, Little Rock  
*Chairman of the Council*

Established 1890. Owned and edited by the Arkansas Medical Society and published under the direction of the Council.

**Advertising Information:** Contact Stephanie Hopkins, P.O. Box 3686, Little Rock, AR 72203; (501) 372-2816.

**Postmaster:** Send address changes to: *The Journal of the Arkansas Medical Society*, P. O. Box 55088, Little Rock, Arkansas 72215-5088.

Subscription rate: \$30.00 annually for domestic; \$40.00, foreign. Single issue \$3.00.

*The Journal of the Arkansas Medical Society* (ISSN 0004-1858) is published monthly by the Arkansas Medical Society, #10 Corporate Hill Drive, Suite 300, Little Rock, Arkansas 72205. Printed by The Ovid Bell Press, Inc., Fulton, Missouri 65251. Periodicals postage is paid at Little Rock, Arkansas, and at additional mailing offices.

Articles and advertisements published in *The Journal* are for the interest of its readers and do not represent the official position or endorsement of *The Journal* or the Arkansas Medical Society. *The Journal* reserves the right to make the final decision on all content and advertisements.

Copyright 2000 by the Arkansas Medical Society.





# Wish You Had Been There

By DAVID WROTEN

**T**he 124th Annual Session of the Arkansas Medical Society is now history. We'll feature highlights from the meeting in next month's issue of *The Journal*. However, I want to use this month's space to tell you what a success the meeting was and to set the stage for getting YOU there next year.

On May 5-6, more than 200 physicians, residents and students turned out for the AMS annual meeting held in Little Rock at the Embassy Suites. Months of planning and revisions paid off in what some long-time attendees agreed was one of the best annual meetings in AMS history.

What made it so great? The revised schedule certainly helped. All of the educational programs were on one day, followed by only one day of business meetings. In the past, the educational programs and business meetings were spread over three days. Those attending mostly business sessions had to plan on two or three days away from home and practice for what amounted to less than a full day of actual meetings. The same was true for those interested only in the continuing medical education programs. As a result of the change, attendance at both CME and business meetings was up significantly.

The topics for the CME activities were another big plus. The topics were current and applicable to a broad range of medical specialties. You be the judge: Biological Terrorism & Medicine; Medical Discoveries in Space; Gene Therapy; Overuse of Antibiotics; and How Can the Internet Help Deliver Efficient, Quality Health Care?

Our efforts to encourage young physicians to attend and become involved were bolstered by the Young Physician Seminar. Nearly 60 young physicians and residents attended a special seminar on joining a group practice or partnership. For a young physician, joining that first practice is both exciting and frightening. Having sat through most of the seminar myself, I can assure you that the physicians who attended are now in a much better position to make wise, informed decisions regarding their future.

No educational meeting is complete without a trade show. It's not easy to get physicians to visit an exhibit center to spend quality time with the various company representatives, especially when there are 80-90 different booths. So we reduced the number of booths to 45. The result: Physicians spent more time with each exhibitor, and more physicians visited the exhibit hall. The commercial sponsors and exhibitors underwrite the majority of the annual session expenses. We appreciate their support and can't say thank you enough.

The business meetings on Saturday were capped with the election of officers and the installation of Dr. Gerald Stolz, a Russellville pathologist, as the new AMS president. Dr. Joe Stallings, a Jonesboro family practitioner, was chosen as president-elect and will assume the office of president at next year's annual session.

U.S. Representative Marion Berry from the 1st Congressional District received the Shuffield Award. The AMS recognized him for his efforts in sponsoring and passing the Patient's Bill of Rights in the U.S. House of Representatives. The Shuffield Award is the highest honor that the AMS bestows on a non-physician.

Bottom line: The 124th Annual Session was well attended and proved to be a huge success for all involved. The new format makes it easier for physicians to commit the time to attend. Our thanks to those physicians, residents and medical students who attended, and our appreciation to the sponsors and exhibitors for their contributions and support. We hope to see more of you there next year! ■

## Family Practice Opportunity in Little Rock

B/C,B/E Family Practitioner or Internist for Busy Out-Patient, Preventive, Urgent/Chronic and Occupational Medical Care. Limited Inpatient Hospital Practice. Light Weekend and Night call. Competitive Salary and Benefits.

**PRIVATELY OWNED PARTNERSHIP OPPORTUNITY.**

**501-562-1463**

Wm.Gary Darwin, M.D., P.A.  
C. Sue Caruthers, M.D.

## You can care for your patients while we take care of business.

*Discover the benefits of ESA's integrated business services for healthcare professionals*

- **Payroll Services**  
- complete payroll management
- **Human Resources**  
- regulatory compliance management
- **Comprehensive Benefits Package**  
- health, dental, vision, 401K
- **Customized Consulting Services**  
- Employee Selection & Training  
- Ensure you have the right team  
- Budgeting and Planning  
- Develop a business plan that works for you.  
- Billing - Turn key service.



(501) 225-7300 • 1-800-344-5551



*Pledging commitment is one of the most important things that human beings can do for one another. It means I'll do only my best for you. I'll fight for your rights. I'll be there for you. At Snell Laboratory we*

*make that type of commitment to each of our patients. We dedicate ourselves to making them as comfortable and as mobile as possible. We give them back as much of their former life as we can.*

# A MATCH MADE IN HEAVEN.



*Our computer-aided design and manufacture (CAD/CAM) system makes so much more possible in creating custom-fit prostheses than ever before. And new lightweight, space age materials mean more for our patients with custom orthoses. So regardless of what responsibilities your*

*patients agree to in life, from going out to play to attending a special occasion, our commitment to comfort never waivers.*

*Snell Prosthetic and Orthotic Laboratory has been in business since 1911. We've said "I do" to our patients since day one.*



**SNELL**  
Prosthetic & Orthotic  
Laboratory

THE LATEST IN TECHNOLOGY. THE BEST IN CARE.

Offices located in Little Rock, Russellville, Fort Smith, Mountain Home, Fayetteville, Hot Springs, North Little Rock, and Jonesboro.

Little Rock (501) 664-2624 • Statewide Toll-free 1-800-342-5541

Founding Members of PrimeCare O&P Network - serving the southern United States.



# Foundation is a 'Lifesaver' to Many Uninsured

## *Physicians Give Free Care to State's Working Poor*

BY NATALIE GARDNER

**S**HIRLEY CARSON, 60, QUITE possibly might have died last year if she hadn't undergone double heart bypass surgery.

Because of an organization that is housed in the Arkansas Medical Society's office and founded by AMS, Carson was able to get the \$22,000 procedure for free. And that doesn't include the countless office visits with her family physician, Dr. George A. McCrary of Cabot, and her cardiovascular physician, Dr. Mark St. Pierre of North Little Rock. All those visits are free, too.

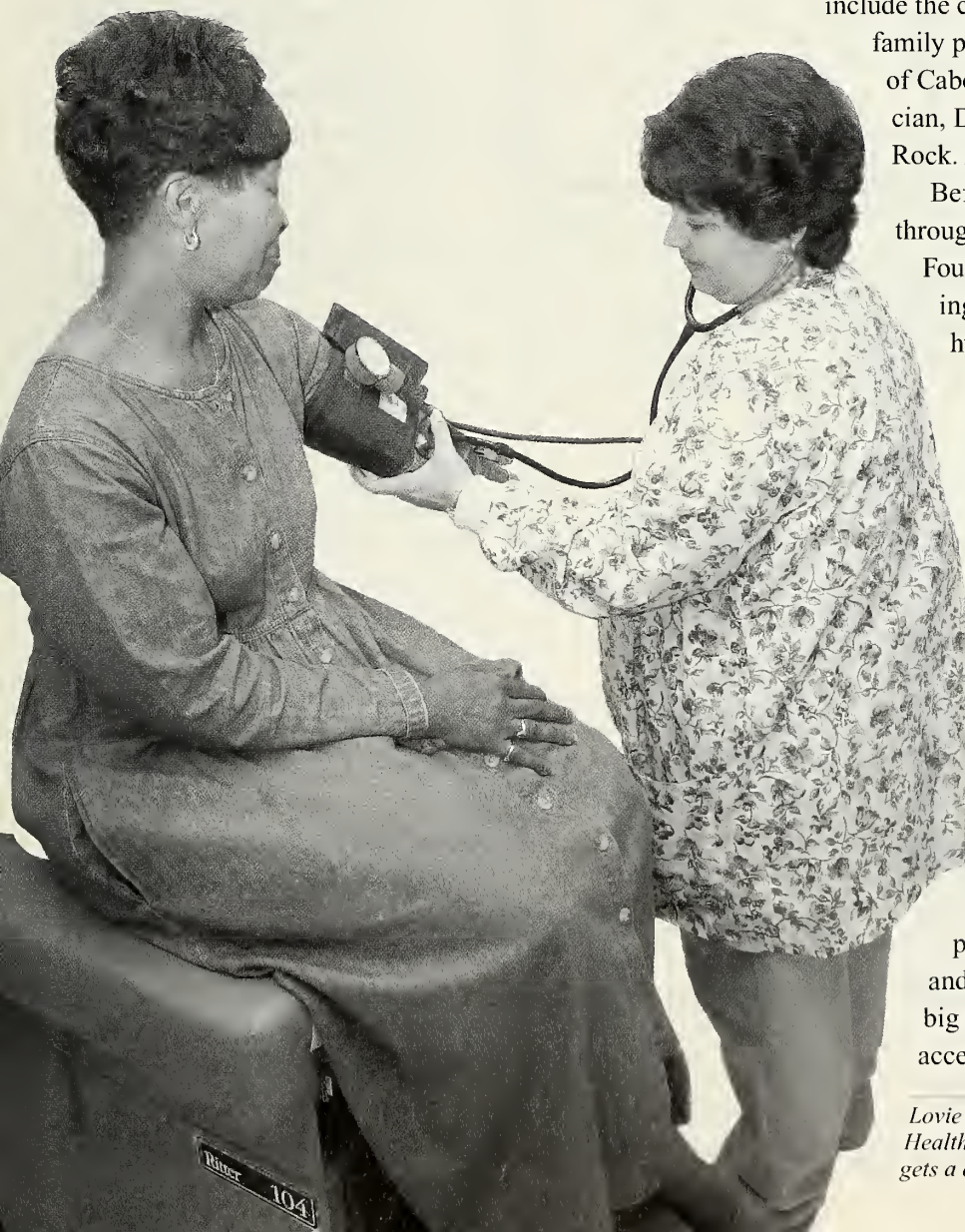
Before signing up to receive care through the Arkansas Health Care Access Foundation Inc., Carson was postponing taking care of her and her husband's health problems.

"I had quit going to the doctor, because at \$80 a visit, we just could not afford it on our limited income," she said.

With extensive health problems, ranging from a bad heart condition, severe arthritis, diabetes and back pains, Carson cannot keep a full-time job. But she has been turned down for disability benefits and is still too young to qualify for Medicare.

The Arkansas Health Care Access Foundation was created to help these exact types of patients. The state's "working poor" and uninsured have always been the big losers when it comes to health care access, said Dr. Harold Hedges, a Little

*Lovie Casey, a patient in the Arkansas Health Care Access Foundation program, gets a check-up.*





# The turn of the century might bug an ordinary hospital.



**F**ortunately, we have some prior experience with such bugs. In fact, a turn of the century bug was how St. Bernards came to be in the first place.

In 1900, St. Bernards Hospital was founded in a six-room frame house to respond to the region's malaria epidemic—spread by none other than the common female mosquito.

In the 100 years since then, St. Bernards has continued to respond to the needs of our community. No longer simply a respite for the ailing, St. Bernards has grown into a regional referral center providing total healthcare services and education to communities all over Northeast Arkansas and Southeast Missouri.

So we aren't frightened by talk of a centennial or millennium bug. Let's just say we're ready for it.



*Where there's a need,  
we see our mission.*

[www.sbrmc.com](http://www.sbrmc.com)

Rock family practitioner and former chairman of the foundation's board of directors.

"We noticed a number of patients who were falling through the cracks as far as medical treatment was concerned," Hedges said. "They were folks who worked and their employer couldn't supply insurance, and they couldn't afford to pay it themselves. It was a huge population of people that didn't qualify for any state or federal programs."

In 1989, the Arkansas Medical Society created the foundation and modeled it after a similar program in Kentucky. Asa Crow, a retired physician in Paragould, was instrumental in forming the Arkansas Health Care Access Foundation.

Arkansas was the second of four states in the United States to create a comprehensive, volunteer health care program for the "working poor," said Program Director Pat Keller.

An estimated \$6 million in medical care and treatment has been provided by the program's 1,900 volunteers at an average cost of \$20 per enrollee. AMS supports the programs through in-kind donations, such as support staff, office space and utilities.

Arkansas residents can apply for the program through their local county Department of Human Services office. To be eligible for the program, applicants must be a U.S. citizen, be a resident of Arkansas, meet the current Federal Poverty Guidelines according to family size, not have any form of medical insurance, including Medicaid or Medicare, or Veteran's Administration medical benefits, and not have more than \$2,000 in liquid resources.

Income level cutoffs for a family of two is \$937.50 per month and \$1,420.83 per month for a family of four.

Once admitted to the program, patients receive a toll-free number to call when they need any type of health care

services. Doctors who volunteer their time for the program are only required to see a patient once, but many, like Dr. Hedges and Dr. Bart Throneberry of Conway, continue to do follow-up sessions with patients.

"With all the time spent on managed-care rules and regulations, I can do this because I want to," Dr. Throneberry said. "It makes me feel really good to do something that helps others. This program goes to the heart of why people wanted to be a doctor — to help those who need to be helped. It's easy to lose sight of that."

### Recruiting Volunteers

Currently, more than 1,900 volunteer health professionals, including 1,100 physicians, volunteer for the program. Along with the physicians, many of the state's pharmacists, podiatrists, dentists, home-health agencies and hospitals volunteer their time and resources to provide free care to patients.

"We don't have a formal agreement with any of the doctors," Keller said. "If a doctor decides in six months that he needs to limit the number of referrals he is getting, then all he has to do is call. We're very accessible to our volunteer physicians."

Many of the family physicians who volunteer see two-three patients a month. Some of the specialists don't see a patient for months, but then will see two patients the next month. Currently, the foundation is in need of more physicians in eastern Arkansas.

Part of the nonprofit's services include arranging for free medications for patients. Getting doctors' visits paid in full helps patients a great deal, but some patients have just as much expense when they fill their prescriptions, Keller said.

"Two-thirds of the pharmacies in the state volunteer their services, giving patients prescriptions at cost," she

## Growth of Your Retirement Investments Is Our Specialty

SEP IRAs  
IRA Rollovers  
401Ks

Using  
**The Optimum  
Performance Strategy  
TOPS**

The Unique Investment  
Program Developed by  
Tom Schallhorn.



**SOUTHWEST CAPITAL  
MANAGEMENT, INC.**

REGISTERED INVESTMENT ADVISOR

Thomas N. Schallhorn, President  
501.374.1119 • 1.888.440.9133

105 West Capitol Avenue, Suite 101  
Little Rock, AR 72201-5732

## Looking for a Few Good Docs.

Exclusive positions are available in Arkansas and nationwide for physicians in many disciplines. Our fees are fully paid by the employers. All information is strictly confidential. Call today for a FREE consultation.

**Medicus**  
RESOURCE GROUP



1-800-394-4007

501-228-4649

501-228-5746 Fax

650 South Shackleford Rd., Suite 400  
Little Rock, AR 72211  
e-mail: medicus@medicusrg.com

## Well-established, multi-specialty group practice

Millard-Henry Clinic is currently recruiting  
for it's Family Practice Department.

Interested in board eligible or board  
certified **Family Practitioners**.

Excellent salary and benefit package.

Interested applicants should contact Millard-Henry's  
administration office at 501-890-2474. Resumes may be  
faxed to 501-890-2482 or mailed to Millard-Henry Clinic,  
101 Skyline Drive, Russellville, Arkansas 72801.

**MH** **MILLARD  
HENRY  
CLINIC**



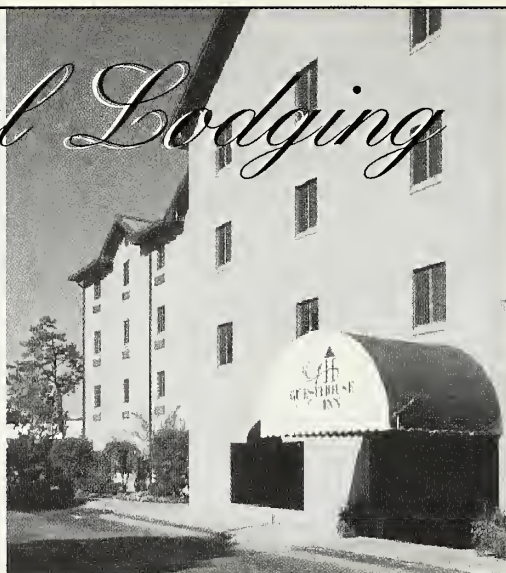
# Medical Lodging

Close proximity to all  
Little Rock hospitals

Serving Little Rock Visitors

- Medical stays
- Business travel
- Leisure travel

"Guesthouse Inn is your  
perfect home away from home  
while in Little Rock"



301 So. UNIVERSITY AVE. ▲ LITTLE ROCK, AR 72205 ▲ (501) 664-6800

## MEDICAL OFFICE SPACE

**DOCTORS BUILDING**  
500 South University Avenue  
Little Rock, Arkansas

Suites Available ranging from  
950 sq. ft. to 4,807 sq. ft.

Professional Management  
Maintenance 24 hours a day, 365 days a year  
Nightly janitorial service plus Day Maid  
Free Doctors Parking Lot -  
Or Low Cost Reserved Parking  
Free Use of Well Appointed Conference/Club Room  
Ancillary Services in Building

**Location convenient to all area Hospitals**  
including Baptist, St. Vincent Doctors,  
St. Vincent Infirmary, UAMS, VA  
and Arkansas Children's.

**CONTACT**  
**Betty Garcia - 664-1812**  
VISIT OUR WEBSITE [www.lirma.com](http://www.lirma.com)

said. "That helps, but so often that is not enough. That's when we went directly to the drug companies to see what they could do."

If a physician prescribes medications from either Pfizer Pharmaceuticals, Johnson & Johnson or SmithKline Beecham Pharmaceuticals, the cost to patients is none.

"These companies have been a life-saver for us," Keller said. "We really encourage the doctors to use medications from these companies. We tell the patients to take the list of all these medications with them to the doctor to help remind the physicians what will be paid for."

Keller and her 20-member board of directors also hope some of the billions of dollars in tobacco money coming to the state will be directed to the program. Currently, the foundation's main source of funding is a contract with the Department of Human Services.

"The board of directors is concerned we're going to be left out when the tobacco money is distributed," Keller said. "I feel that we are in a good position — we've got a screening process in place for patients, we have good relationships with our providers and we have a large database of patients. We just want to make sure that part of that money is set aside to take care of this population, maybe through partial reimbursement to doctors or partial reimbursement for follow-up care or for illnesses due to smoking."

### Lending a Helping Hand

The real joy for Keller, her staff and the volunteers associated with the program is the difference they are making in patients' lives.

"I'm doing this program because I choose to," Dr. Throneberry said. "Doctors, recently, have been so angry, frustrated and busy with rules and regulations, we sometimes forget why we do what we do. Treating these patients helps me bring things back into perspective."

And the patients truly are grateful. "For me, it's the initial doctor visit that is such a big help, and my really expensive prescriptions are free," said Brian Brengle, 33, a Hot Springs minister in the program.

Brengle, who makes about \$500 a

asked to be anonymous said even though she couldn't afford her care, she was treated with the utmost respect by all of her care givers.

"Sometimes when people cannot afford to pay for things, they don't get good treatment," she said. "But that has

capable of paying any medical expenses. Until she gets better and can go back to work, the foundation has been a "blessing," she said.

"There's no way I could have afforded to get a mammogram or a colonoscopy without them," she said.

**"The doctors in this program are a better quality than what I got in my HMO." — Brian Brengle, 33.**

month, has struggled with paying steep medical bills. He qualified for the program in 1994 and has gotten free treatment for severe arthritis, high blood pressure and a spastic colon.

"I used to have an HMO [health maintenance organization] when I could afford it," he said. "The doctors in this program are a better quality than what I got in my HMO."

A former nurse in her 50s who

not been my experience with this program. There was no partiality shown to [paying patients]. I was treated just like everyone else."

The Arkansas Health Care Access Foundation often helps people like this nurse. She was injured in a car accident in 1996 and stopped working because of severe hip and back injuries. Prior to the accident, she was making a comfortable salary and was

"It's been a blessing in disguise for me.

"If I was in a position right now to donate my [nursing] services, I would. Any [health care professional] who is able to participate in this program could get so much satisfaction from helping the people who need it the most." ■

*Christy L. Smith contributed to this report.*

**50 years**  
of  
**collection experience**

Freemyer Collection System has been helping businesses eliminate their bad debt problems since 1941. When you work with the trained professionals at Freemyer, you get many benefits.

- Bad debts are collected at a competitive contingency fee.
- Representatives are on-hand for questions and problems.
- You don't pay fees unless collections are made.

Call one of our representatives today at 1-800-955-2225 and let us help you with your business's debts.

A proud supporter of the  
Arkansas Medical Society Convention



AMERICAN COLLECTORS  
association member

Endorsed by AHA Services, Inc.  
A subsidiary of the  
Arkansas Hospital Association



**Freemyer  
Collection  
System**

**1-800-953-2225**



# Meet Our Members

## James Harrell Jr., MD

BY CHRISTY L. SMITH

Dr. James Harrell Jr. has performed more than 100 heart transplants at Arkansas Children's Hospital since the institution's pediatric heart transplant program was established in 1991.

But the 47-year-old cardiovascular surgeon and surgical director of the ACH Heart Center appears to still be amazed by the miracle of life.

"I've done a fair amount of adult surgeries, but pediatrics is a subfield of cardiovascular surgery that I particularly enjoy. It is tremendously satisfying to take a baby, fix his heart and know that you have changed his life expectancy, given him another 50 or 60 years of life," Dr. Harrell said.

The surgeon performs eight-10 cardiovascular procedures — closing holes in a patient's heart and reconstructing valves, arteries and heart walls — per week; and he conducts an average of 12 pediatric heart transplants per year.

Most of Dr. Harrell's transplant patients hail from Arkansas, but ACH also takes referrals from Mississippi, Louisiana, east Texas, east Oklahoma and Tennessee. Two former patients even traveled from as far as Kansas and Connecticut to receive a heart transplant on Dr. Harrell's surgical table.

"For a children's hospital, we have a lot of volume," he said. "We're really proud of the program ... Arkansas is often seen as a poor Southern state, but we are achieving astounding things in the medical field here."

### Setting an Example

There are only 141 heart transplant programs in the country, ac-

cording to the United Network for Organ Sharing, the agency that matches organ donors with waiting recipients, and Dr. Harrell oversees the only pediatric heart transplant program in Arkansas.

A U.S. Department of Health and Human Services report issued this year ranked the heart transplant program at Arkansas Children's Hospital ninth in the nation for one-year survival of patients after placement on a waiting list. ACH beat the national average of 75.8% by 8.8 percentage points.

Only two other children's hospitals made the list — All Children's Hospital in Florida (fourth) and Children's Memorial Hospital in Chicago (eighth).

ACH also ranked 10th for transplants completed within one year of patient placement on the waiting list. The national average was 53.7%; the ACH average was 72.4%.

Only three





other children's hospitals made that list — All Children's Hospital in Florida (first), Children's Hospital in Denver (third) and Children's Hospital in Boston (sixth).

### The World of Medicine

Dr. Harrell's talents were nearly lost to the medical profession when, as a Harvard University undergraduate, he became interested in global economics.

The son of a physician and Army reservist, Dr. Harrell spent much of his childhood growing up in south Arkansas, Texas and Washington, D.C. He studied economics at Harvard until he was accepted into the DeBakey Surgical Summer Scholarship Program at Houston's Baylor College of Medicine.

For three months in 1974, he followed the work of Dr. Michael E. DeBakey, a world-renowned medical pioneer who served as a consultant on the 1996 bypass surgery of former Russian President Boris Yeltsin.

"I saw everything that summer — heart surgeries, gun shot wounds. It was all so interesting and exciting. I immedi-

ately changed my career path," he said.

After graduating from Harvard with a general studies degree — he did not complete his senior thesis in economics — Dr. Harrell entered Baylor College of Medicine, where his father is now chief of radiology.

He completed general surgery residencies at Baltimore's Johns Hopkins University Hospital and Houston's University of Texas Health Science Center, a two-year thoracic surgery residency at Baylor, a cardiovascular research fellowship at Baylor and a pediatric cardiovascular surgery fellowship in London, England.

From 1980-89 he also found time to serve in the U.S. Army Reserve Medical Corps, in which he taught a combat casualty care course and achieved the rank of major.

Dr. Harrell spent two years practicing in California before moving to Little Rock to become attending staff surgeon and acting chief of staff at ACH in 1989. He also has surgical and administrative responsibilities at the VA Medical Center and University Hospi-

tal, both in Little Rock; and he was director of the thoracic surgery residency program at the University of Arkansas for Medical Sciences from 1990-98.

Dr. Harrell is a member of the Governor's Task Force on Organ Donation, a group trying to increase the rate of organ procurement in this state, and 11 other professional organizations. He has been a member of the Arkansas Medical Society since 1989 and has participated in the society's "Doctor for a Day" program.

Dr. Harrell said the Arkansas Medical Society has been an "invaluable" resource for information about the legislation affecting Arkansas patients and physicians.

"I am particularly grateful for the Medical Society's involvement in state legislative affairs. It has certainly taken an active role in advocating for the protection of patients' rights and, likewise, looking out for the interests of Arkansas physicians," he said.

He is married to Marty Harrell, a CV nurse at Arkansas Children's Hospital, and has three children from a previous marriage — one son, Wells, 15; and two daughters, Elizabeth, 13, and Lauren, 12. ■

## HEALTHY WEALTHY & WISE.

*Financial  
strategies  
specifically for  
physicians.*

At Hutchinson/Ifrah,  
we understand the issues  
that put a physician's practice  
and personal assets at risk.  
But our idea of being healthy,  
wealthy and wise is more than  
simply saving on taxes and  
protecting your assets,  
it's about maximizing your  
investment potential and  
planning for a tax-free  
retirement. Give us a call at  
501/223-9190 and let us show  
you how we can help physicians  
achieve a healthy bottom line.



Hutchinson/Ifrah  
Financial Services, Inc.  
*Registered Investment Advisors*

WE REALIZE YOUR POTENTIAL.

12511 Cantrell Road • Little Rock, Arkansas 72223  
(501) 223-9190 • 800-635-9985  
[www.hutchinson-ifrah.com](http://www.hutchinson-ifrah.com)



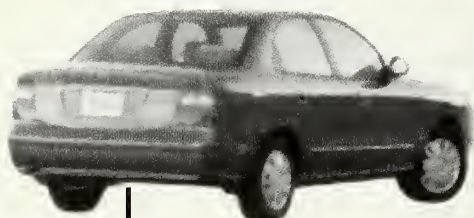


# The New Daewoos Are Here!



**We may not be a household name yet. But with features like German engineering and Italian styling, we will soon. And our 3 year, 36,000 mile warranty covers virtually all scheduled maintenance - even oil changes.**

***Just gas and go!***



**Nubira**  
4 dr. CDX  
**\$14,755**

Automatic, anti-lock brakes, power windows, power door locks, cruise, anti-theft system, luxury value package. No charge. stk# E40008

**Lanos starting at**  
**\$9,995**



stk# D30002

**Laganza**  
4 dr. SX  
**\$17,965**

Automatic, leather, anti-lock brakes, power windows, power door locks, tilt, cruise, anti-theft system, alloy wheels, power moonroof. stk# F40005



**5921 S. University Ave. Little Rock**  
**562-9310 or Toll Free 1-800-562-9310**

[www.daewooarkansas.com](http://www.daewooarkansas.com)



# Negligence or Not

J. KELLEY AVERY, MD

**Experts for the plaintiff contended that the omission of the preoperative prophylactic antibiotics was a negligent act. They also insisted there was too much telephone treatment and not enough direct observation by the physicians early in the case.**

A 51-year-old housewife who was the principal caregiver for a paraplegic husband saw an orthopedic surgeon for pain in both feet, worse on the right. She thought she had some painful calluses on her feet that caused pain when she stood.

The pain became worse the longer she was on her feet. Caring for her husband required that she be up and on her feet most of every day. Examination revealed pain on lateral compression of the metatarsal heads bilaterally. She also had a positive "pinch test" over the web spaces between the second, third and fourth metatarsals. She was thought to have neuromas between the second and third and the third and fourth metatarsals. Both interspaces were injected with steroids on that visit. She did not improve.

Two weeks later the patient was admitted to an outpatient surgical center for removal of the neuroma. No prophylactic antibiotics were given preoperatively. The operation was carried out in the usual manner, using general anesthesia and a pneumatic tourniquet.

Incisions were made in both interspaces, and by blunt and sharp dissection, neuromas were removed from both interspaces. Gelfoam was placed in both incisions, and when the tourniquet was released there was good blood flow. A pressure dressing was applied, and after fully recovering from the anesthesia, the patient was sent home to return to the surgeon's office in one week. The pathology report confirmed the diagnosis.

After midnight the following day, the patient had to go the emergency department because of severe pain in her foot not relieved by oral narcotics. There was no report of the emergency visit in the record of the surgeon. The patient phoned the office and reported the visit

stating that two toes were purple and cold. The dressing was rewrapped, and she was instructed to call. Later the same day the office called, and the patient stated that she was, "much better this morning."

The office records do not document the visit that occurred one week after surgery. Three days after this visit was to take place, the office records show that Vicodin No. 100 were called to the pharmacy for the patient. The next day she called to report swelling every time she got up on her feet.

The swelling subsided on elevation of the foot. She wanted to know if this was normal. She stated that she had an appointment in three days for the stitches to be removed and the record quotes the patient, "Please call." She was reassured that the swelling was normal and that she should keep the foot el-

evated as long as this swelling continued.

On the day appointed, two weeks after surgery, the sutures were removed. She was seen by an associate of her surgeon's who recorded "rather massive"



blood clot under the skin at the operative site. She was given antibiotics and told to use salt water soaks and to return in a week. Four days later she was seen in the office. Although there is no documentation of this visit other than that she was in the office. I presume that the operative site "hematoma" was drained. Two days later, there was a report of "heavy growth of staph aureus" from the drainage, and the patient was admitted to the hospital. Having been seen in the office and the emergency department by an associate of her operating surgeon, she stated her preference to continue to see the associate, but the operating surgeon assumed her care on that admission. Two ulcerations were





## The sign of comprehensive healthcare in South Arkansas



## Medical Center of South Arkansas

A SHARE Foundation Partnership [www.mcsaeldo.com](http://www.mcsaeldo.com)

## NORTHEAST ARKANSAS

Seeking BC/BP Emergency Medicine or Primary Care physicians for EM opportunities in northeast Arkansas. Hospital locations are convenient to Little Rock and Memphis. Annual volumes range from 6,500-35,000. Competitive remuneration, procured malpractice & Independent Contractor status. All inquiries are confidential. Contact Traci Mahlmeister with PhyAmerica @ 800-476-5986, fax CV to 919-382-3274 or e-mail [tmahlmei@phyamerica.com](mailto:tmahlmei@phyamerica.com).



**PhyAmerica**  
Physician Services, Inc.

present on the dorsum of the foot draining purulent material.

She was in the hospital for two weeks receiving intravenous Kefzol and Gentamicin, and physiotherapy (whirlpool). While in the hospital, debridement of the operative sites was done, with the removal of devitalized tissue. At the time of discharge from the hospital there did not appear to be any active infection, and the wounds were said to be healing and clean.

A home health nurse was in her home attending her husband and reported that the drainage coming from the wound "was greenish in color and had a foul odor to it." She was seen the next day in the office by the associate, who changed antibiotics and prescribed daily whirlpool treatments. It

The physician elected to resume antibiotics. A week later, when the patient reported more discolored drainage and "red streaks" from the toes to the ankle area, she was readmitted to the hospital.

was then two months since the operation, and the wound was draining and showing lots of "debris." The physician elected to resume antibiotics. A week later, when the patient reported more discolored drainage and "red streaks" from the toes to the ankle area, she was readmitted to the hospital.

Antibiotics were changed again. Shortly after the first dose of the new antibiotic the patient had a seizure from which she recovered spontaneously. She had an EEG done, which was "abnormal." The consultant said she had a "predisposition to seizures." The conclusion was that the seizure was due to a reaction to the antibi-



otic. She was seen by a plastic surgeon about the possibility of covering the wound to enhance healing. This was not done. MRI failed to show any evidence of osteomyelitis, and after a month in the hospital, the patient was sent home to continue intravenous antibiotics via a Hickman catheter and under the supervision of the home health nurse.

Finally, six months after the initial operation, the wound appeared healed, but there was still severe pain in the foot. The patient would require another operation to remove "stump neuroma" at both original sites, and she would subsequently be hospitalized seven more times because of problems with her foot.

A lawsuit was filed against both surgeons who treated this patient charging negligence in not giving preopera-

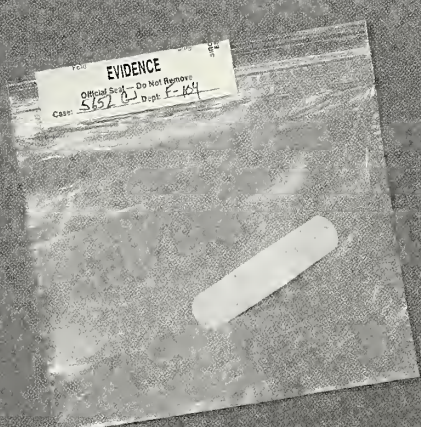
**A lawsuit was filed against both surgeons who treated this patient charging negligence in not giving preoperative antibiotics; wrapping the dressing too tightly; failure to continue the antibiotics following discharge from the hospital after the first admission; and failure to consult an infectious disease specialist.**

tive antibiotics; wrapping the dressing too tightly; failure to continue the antibiotics following discharge from the hospital after the first admission; and failure to consult an infectious disease specialist. After six years of litigation, a settlement was reached.

**Loss Prevention Comments**

Was this a case of negligent physician acts, or was it a case where the outcome was certainly not good, but was in the area of hazards that occur despite treatment that can be considered standard and acceptable? Experts for the

plaintiff contended that the omission of the preoperative prophylactic antibiotics was a negligent act. They also insisted there was too much telephone treatment and not enough direct observation by the physicians early in the case. Certainly after the beginning of the infections, all physicians would have wished that the patient had received the antibiotics. The defendant physicians' experts, equally qualified in the field of orthopedic surgery, stated that while many surgeons routinely gave the preoperative prophylactic antibiotics, it was not considered "standard" at the time this surgery was done. Many similar procedures had been done without the prophylactic drugs, where no serious infection had occurred, but that is not this case. There were factors that would have weighted the case heavily in favor of



**Exhibit A:**

Adhesive bandage, which plaintiff alleges defendant pulled rapidly from skin, violently tearing three hairs from plaintiff's arm, which resulted in severe shock, trauma, disfigurement, chronic debilitating pain and permanent psychological damage.

To protect your reputation, we take every claim seriously.

Even the most absurd claims can be damaging if they're not handled properly. Which is why the full weight of our more than 60 years of experience in medical liability insurance is brought to bear on each and every claim, no matter how frivolous that claim may appear. In fact, when appropriate, we have appealed cases all the way to the United States Supreme Court, at no additional cost to policyholders. Because you can't put a bandage on a damaged reputation.

**The St Paul**

©2000 St. Paul Fire and Marine Insurance Company  
Coverages underwritten by St. Paul Fire and Marine Insurance Company or another member of The St. Paul Companies  
[www.stpaul.com](http://www.stpaul.com)



## There are plenty of full service banks. So where are all the full service bankers?

If you want the type of personal service that's missing from most full service banks these days, call Metropolitan National Bank's Professional Banking Group. Our highly specialized team, led by Senior Vice President George Penick (978-7632), focuses exclusively on helping those with substantial assets, but limited time to maximize their potential.

Just make the SimpleSwitch to our Professional Banking Group at Metropolitan. We'll give you the personal service you've been looking for.



Little Rock, North Little Rock, Sherwood,  
Benton, Bryant and Conway

N E A R B Y & N E I G H B O R L Y.

[www.metbank.com](http://www.metbank.com)

Member FDIC



## *"Our Family Caring for Yours"*

At Helena Regional Medical Center,  
our patients are more than just customers.

They're "family." And for our family,  
only the best will do—especially  
when it comes to health care.

You can rest assure that HRMC's  
professionals are up to the challenge of  
giving you and your family quality care,  
at an affordable price.

**Helena Regional**  
MEDICAL CENTER

the plaintiff had it been taken to trial. The plaintiff was an attractive middle-aged wife and mother. She was very intelligent and made a favorable impression. She had a paraplegic husband for whom she was the principal care giver. She had this responsibility for several years before the surgery, and indeed it was because of her need to care for her husband that the surgery was necessary. She was considered a superior witness. The paraplegic husband was scheduled to testify in person at the trial. He would say that he had been emotionally damaged by the absence of his wife's care during the long months when she was not able to care for him. He also was thought to be an exceptionally good witness. A strong sympathy factor was expected and feared.

On the other hand, the surgeon was tentative, nervous and very much traumatized by a previous trial in which the plaintiff attorney vigorously cross examined him. He was not considered to be a good witness. He could not be relied upon to represent himself well. His office records were not good, and the records of this patient's visits to the ED were not a part of them. The surgeon had not acted as if it was important to see the report of the ED physician who had actually seen his patient and observed the wound. His patient had gone so far as to request, in the middle of things, that his associate assume charge of her care.

The actual expenses borne by the plaintiffs were in the six-figure range. The settlement, in the range of two times the actual expenses, was considered to be a victory. It may not be right, but that is the world in which we live.■

*The case of the month is taken from actual Tennessee closed claims. An attempt is made to fictionalize the material in order to make it less easy to identify. Dr. Avery is a member of the Loss Prevention Committee, State Volunteer Mutual Insurance Co., Brentwood, Tenn. This article appeared in the March 2000 issue of Tennessee Medicine. It is reprinted with permission.*



# Arkansas Department of Health HIV/AIDS Surveillance

**STATE  
HEALTH  
WATCH**

## HIV in Arkansas

March 31, 2000

Demographics	83-92	1993	1994	1995	1996	1997	1998	1999	2000	Total	%
Male	1622	338	342	321	262	261	286	268	82	3782	81
Female	289	89	89	89	77	92	70	85	24	904	19
Under 5	25	3	5	2	1	8	4	6	0	54	1
5-12	8	0	0	1	0	0	0	3	0	12	0
13-19	72	11	21	11	21	18	10	11	2	177	4
20-24	246	59	57	44	29	36	32	40	16	559	12
25-29	448	106	79	73	60	53	59	46	11	935	20
30-34	451	89	93	97	81	76	74	67	20	1048	22
35-39	310	75	69	80	70	64	76	68	26	838	18
40-44	167	45	48	46	34	48	47	49	18	502	11
45-49	85	16	27	22	18	33	26	30	5	262	6
50-54	43	10	10	16	14	8	16	14	3	134	3
55-59	28	6	6	6	5	6	5	9	4	75	2
60-64	11	5	9	6	1	2	3	6	1	44	1
65+	17	2	7	6	5	1	4	4	0	46	1
White	1234	264	243	252	186	179	186	190	58	2792	60
Black	661	158	177	150	142	160	149	139	39	1775	38
Hispanic	9	2	7	3	6	5	7	7	5	51	1
Other/Unknown	7	3	4	5	5	9	14	17	4	68	1
Male/Male Sex	1049	230	212	176	153	131	161	133	23	2268	48
Injection Drug User (IDU)	310	61	72	61	35	59	41	36	5	680	15
M/M Sex + IDU	184	30	24	29	26	19	14	11	2	339	7
Heterosexual/ Known Risk	236	96	97	74	76	85	55	55	5	779	17
Transfusion	40	1	2	5	2	1	2	1	0	54	1
Perinatal	25	3	5	3	1	8	4	6	0	55	1
Hemophiliac	35	2	3	5	0	0	2	0	0	47	1
Undetermined	32	4	16	57	46	50	77	111	71	464	10
<b>Total</b>	<b>1911</b>	<b>427</b>	<b>431</b>	<b>410</b>	<b>339</b>	<b>353</b>	<b>356</b>	<b>353</b>	<b>106</b>	<b>4686</b>	<b>100</b>

## HIV Cases by County

County	1983-03-31-00	Jul 98 Jun 99	County	1983-03-31-00	Jul 98 Jun 99
Arkansas	23	*	Lee	21	*
Ashley	21	0	Lincoln	5	0
Baxter	36	0	Little River	19	0
Benton	122	16	Logan	10	0
Boone	34	*	Lonoke	29	*
Bradley	16	0	Madison	6	*
Calhoun	8	0	Marion	8	*
Carroll	45	*	Miller	119	13
Chicot	23	*	Mississippi	63	*
Clark	23	0	Monroe	20	4
Clay	4	0	Montgomery	7	0
Cleburne	16	0	Nevada	6	0
Cleveland	*	0	Newton	11	*
Columbia	26	*	Ouachita	42	4
Conway	28	*	Perry	6	*
Craighead	91	4	Phillips	49	0
Crawford	41	4	Pike	*	0
Crittenden	210	22	Poinsett	16	*
Cross	26	*	Polk	13	0
Dallas	10	*	Pope	60	0
Desha	21	0	Prairie	6	0
Drew	15	0	Pulaski	1532	119
Faulkner	69	*	Randolph	6	*
Franklin	12	*	St. Francis	92	*
Fulton	4	0	Saline	36	4
Garland	183	15	Scott	*	0
Grant	6	*	Searcy	5	0
Greene	23	*	Sebastian	255	23
Hempstead	27	*	Sevier	12	0
Hot Spring	27	*	Sharp	11	0
Howard	11	0	Stone	7	*
Independence	32	*	Union	150	14
Izard	9	0	Van Buren	7	*
Jackson	10	0	Washington	343	19
Jefferson	193	13	White	51	7
Johnson	11	0	Woodruff	4	0
Lafayette	9	*	Yell	16	*
Lawrence	14	0	Prisons	152	13

\* Case numbers 1-3 are not indicated

## AIDS in Arkansas

March 31, 2000

Demographics	83-92	1993	1994	1995	1996	1997	1998	1999	2000	Total	%
Male	807	325	253	235	213	179	174	159	60	2405	85
Female	98	63	42	36	54	46	40	30	18	427	15
Under 5	16	2	1	2	0	8	4	1	0	34	1
5-12	-1	0	0	2	0	0	2	1	0	8	0
13-19	9	4	3	1	4	2	2	1	0	26	1
20-24	61	31	22	11	14	11	12	7	3	172	6
25-29	206	78	45	46	46	29	32	20	8	509	18
30-34	217	96	80	73	75	51	43	37	15	688	24
35-39	178	77	52	49	54	55	50	41	20	576	20
40-44	99	48	40	35	37	35	28	37	17	376	13
45-49	54	26	22	17	20	20	19	23	5	206	7
50-54	21	10	12	14	5	6	15	7	5	95	3
55-59	21	8	5	7	7	4	1	7	3	63	2
60-64	7	5	10	5	1	1	4	4	2	39	1
65+	13	3	3	9	4	3	2	3	0	40	1
White	658	264	189	173	145	130	116	108	42	1825	64
Black	237	120	103	95	116	89	86	70	31	947	33
Hispanic	5	3	2	3	4	3	6	2	4	32	1
Other/Unknown	5	1	1	0	2	3	6	9	1	28	1
Male/Male Sex	546	228	163	139	129	95	100	98	33	1531	54
Injection Drug User (IDU)	114	68	47	47	28	50	36	19	7	416	15
M/M Sex + IDU	115	30	25	27	24	10	10	10	3	254	9
Heterosexual/ Known Risk	58	52	41	36	62	44	35	32	17	377	13
Transfusion	33	1	5	4	3	1	2	1	0	50	2
Perinatal	16	2	1	3	0	8	5	2	0	37	1
Hemophiliac	16	5	6	7	1	0	2	0	0	37	1
Undetermined	7	2	7	8	20	17	24	27	18	130	5
<b>Total</b>	<b>905</b>	<b>388</b>	<b>295</b>	<b>271</b>	<b>267</b>	<b>225</b>	<b>214</b>	<b>189</b>	<b>78</b>	<b>2832</b>	<b>100</b>

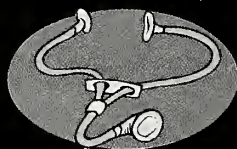
## AIDS Cases by County

County	1983-03-31-00	Apr 99- Mar 00	Case Rate per 100,000			
Arkansas	10	*	4.8	Lee+	14	*
Ashley	16	0	0.0	Lincoln	7	0
Baxter	25	*	5.5	Little River+	10	*
Benton	89	4	3.1	Logan	9	0
Boone	26	*	6.3	Lonoke	24	0
Bradley	13	0	0.0	Madison	5	*
Calhoun	7	0	0.0	Marion	6	*
Carroll	27	0	0.0	Miller+	71	10
Chicot	16	*	13.2	Mississippi	26	*
Clark	13	*	4.5	Monroe+	11	*
Clay	*	*	5.7	Montgomery	5	0
Cleburne	10	0	0.0	Nevada	*	0
Cleveland	4	0	0.0	Newton	5	0
Columbia	18	*	4.0	Ouachita	26	*
Conway+	18	*	15.0	Perry	4	0
Craighead	53	*	2.6	Phillips	22	0
Crawford	31	*	2.0	Pike	*	0
Crittenden+	114	10	20.1	Poinsett	8	0
Cross	12	0	0.0	Polk	10	*
Dallas	8	*	10.9	Pope	30	*
Desha	14	*	13.1	Prairie	7	0
Drew	9	*	11.3	Pulaski+	930	57
Faulkner	53	*	3.9	Randolph	4	0
Franklin	8	*	6.1	St. Francis	41	*
Fulton	*	0	0.0	Saline	21	0
Garland+	123	19	22.8	Scott	*	0
Grant	*	0	0.0	Searcy	5	0
Greene	12	0	0.0	Sebastian+	163	17
Hempstead	14	*	13.7	Sevier	8	0
Hot Spring	22	*	7.0	Sharp	8	0
Howard	7	*	7.2	Stone	*	0
Independence	20	*	6.1	Union+	84	7
Izard	9	*	7.7	Van Buren	6	*
Jackson	4	0	0.0	Washington	213	20
Jefferson	115	11	13.4	White	33	*
Johnson	7	0	0.0	Woodruff	4	0
Lafayette	6	0	0.0	Yell	12	*
Lawrence	13	*	5.7	Prisons	37	4

\* Case numbers 1-3 are not indicated + Denotes top ten case rates 04/99-03/00

For More Information: HIV/AIDS Statistics: Mischelle Priebe, (501) 661-2323;  
HIV Services: Renee Patrick (501) 661-2292; STD Statistics: Rupa Sharma, (501) 661-2139

# CARDIOLOGY



## Iron Overload and the Heart

NELLY KAZZAZ, MD — CHANNARAYAPATNA KISHAN, MD  
EDITOR: EUGENE S. SMITH, III, MD

*Most heart failure is due to hypertension or coronary artery disease. Other causes are possible, and the clinician must always be alert to etiologies that are potentially reversible. This case describes a patient with probable hemochromatosis identified at the time of presentation with congestive heart failure.*

### Case Presentation

Mr. RF is a 50-year-old white male with recently diagnosed type II diabetes mellitus requiring insulin; liver disease with thrombocytopenia related to his heavy alcoholism; and hepatitis B and C, presented to the emergency room with palpitations, chest discomfort and shortness of breath. Patient had noted generalized weakness and fatigue, unrecommended weight loss and abdominal discomfort with increased abdominal girth. His review of systems was significantly positive for orthopnea, paroxysmal nocturnal dyspnea, decreased libido and easy bruisability.

He reported a history of heavy alcohol use and intravenous drug ex-use; he denied any use of over-the-counter supplements, no history of blood transfusions and no family history of liver disease. On initial exam the patient was in moderate distress with a blood pressure of 108/76 mm/Hg, pulse rate 180 per minute (irregular initially). Neurological exam was non-focal with peripheral neuropathy; the chest was clear.

The cardiac exam demonstrated an irregularly irregular rhythm, a grade II/VI systolic murmur heard best over the apex with radiation to the axilla and a laterally displaced apical impulse. The abdomen was distended with a moder-

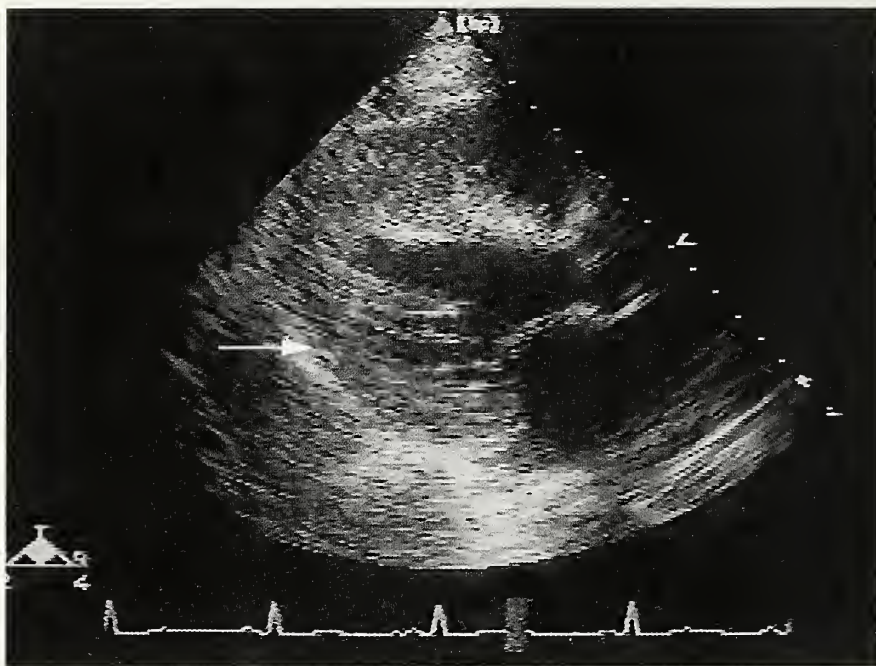


Fig. 1: A granular appearance of the myocardium suggests an infiltrative process.

ate amount of ascites and hepatomegaly; lower extremities showed trace edema, and his skin was tan colored. Initial laboratory results revealed a platelet count of 47,000 (per  $\text{mm}^3$ ), a white blood cell count of 3,490 (per  $\text{mm}^3$ ), with a normal differential and his hematocrit was 42.6%. Electrolytes and kidney functions were normal; INR was 1.4 and thyroid stimulating hormone measured 2.8 ( $\mu\text{U/L}$ ). Electrocardiogram demonstrated atrial fibrillation with rapid ventricular response. He converted to normal sinus rhythm after one dose of diltiazem intravenously.

One physician noticed his skin color and suspected a possible iron overload disorder. Iron studies revealed serum iron of 214 mg/dl (normal range 52 to

183), a total iron binding capacity of 241 mg/dl (normal range 265 to 430), a ferritin of 624 ng/ml (normal range 42 to 262) and a transferrin saturation of 89% (normal range 22 to 46). A liver biopsy was recommended but was refused by the patient; genetic testing for known mutations of the HFE gene was negative. An echocardiogram showed concentric left ventricular hypertrophy, four chamber dilatation, global hypokinesis, trace aortic regurgitation, mild to moderate mitral and tricuspid regurgitation and an ejection fraction of 25-30%. A granular appearance of the myocardium suggested an infiltrative process (Figure 1).

The patient received treatment for his systolic dysfunction. Cardiac mag-



netic resonance imaging was scheduled as an outpatient to confirm the diagnosis of hemochromatosis (HC). Despite education describing the importance of initializing treatment and screening of other family members, he failed to return for follow-up.

## Discussion

Iron loading resulting in organ damage was recognized over 100 years ago. It was first described in 1865 by Trousseau and named by Van Recklinghausen in 1889.<sup>1</sup> The most common cause of iron loading is hereditary hemochromatosis, which is caused by a missense mutation in the HFE gene on chromosome number 6 and was recently identified by Feder, et al. in 1996.<sup>2</sup> Other causes such as thalassemia, sideroblastic anemia, recurrent blood transfusions, alcoholic cirrhosis, porphyria cutanea tarda and congenital atransferrinemia also are described.

Although iron overload is much less common than iron deficiency, its early diagnosis and treatment are still crucial because of the reversible and possible fatal effects on major organs, particularly the heart. Hemochromatosis is thought to have a selective advantage in an era when dietary iron was relatively scarce. However, the 20th century has been accompanied by an increased meat consumption and an increased life expectancy, therefore, hemochromatosis is a prominent disease and no longer advantageous.<sup>3</sup> The prevalence of HC is about 0.3% with a carrier state in up to 10% of the European population. Factors such as dietary iron intake or regular blood loss such as menstruation modifies its clinical expression. It is therefore five to 10 times more frequent in males than females.<sup>4</sup> Membrane damage through lipid peroxidation and promotion of increased collagen synthesis are the most acceptable theories for pathogenesis of iron-induced organ damage.<sup>5</sup>

## Non-Cardiac Manifestations of Hemochromatosis

Symptoms usually develop in the fourth-sixth decade, occurring 10 or more years later in women. Early symptoms are usually non-specific such as fatigue, weakness, weight loss, abdominal or joint pain, loss of libido, impotence and infertility. The characteristic clinical signs of HC in-

clude diabetes mellitus, skin hyperpigmentation and liver disease.

## Cardiac Manifestations

ECG and echocardiographic changes secondary to myocardial iron loading precede symptoms. The most common cardiac complications are congestive heart failure and cardiac arrhythmias, which are the presenting manifestations in 5%-15% of symptomatic patients. The most common cardiac arrhythmias are ventricular because of higher iron deposition, but supraventricular arrhythmias and atrioventricular blocks also are noted. The SA node is affected less often and has been demonstrated both clinically and histologically.<sup>6,7</sup> The effect of iron loading on coronary arteries is controversial. Some studies suggest promotion of atherosclerosis by enhancing the oxidation of LDL (a critical step in developing atherosclerosis), while other studies describe it as an independent factor.<sup>8</sup>

## Diagnosis

Hemochromatosis is diagnosed by clinical suspicion, screening blood tests, genetic testing and liver biopsy. Definitive diagnosis of cardiac involvement with iron loading is very challenging and must exclude other etiologies such as ischemic heart disease or long-standing hypertension. Echocardiographic changes are not very sensitive but usually reveal features of dilated cardiomyopathy and global systolic dysfunction. The deposition of iron interferes with myocardial relaxation leading to diastolic dysfunction.<sup>9,10</sup> Endomyocardial biopsy has a low yield since the deposition of iron may be focal.<sup>11</sup> MRI also has been used since iron disturbs the magnetic field homogeneity; the degree of signal alteration is related to the intrinsic tissue iron levels.<sup>10</sup>

## Treatment

Life-long phlebotomy is required in patients with genetic hemochromatosis with follow-up of total body iron and ferritin levels. Chelation therapy also is used in patients with secondary iron overload.

## Prognosis

Early diagnosis and treatment may allow reversal of organ damage and re-

store normal life expectancy. The amount of iron deposition in the myocardium, which can be estimated by MRI, is considered a prognostic factor.

## Conclusion

Iron overload is an important cause for reversible cardiac disease; therefore, high clinical suspicion is required for early diagnosis and treatment. Newer diagnostic techniques may assist early detection especially if applied to patients in high-risk groups. ■

## References

1. Worwood M. Hemochromatosis: pathological or beneficial. Dept of Haematology, University of Wales College of Medicine 1998: 1925-1933.
2. Crawford D, et al. Hemochromatosis. Bailliere's Clinical Gastroenterology 1998; Vol 12, No. 2: 209-225.
3. Andrews N, Levy J. Blood. The Journal of the Am. Soc. of Hematology Sept 1998; Vol 92, No 6: 1845-1851.
4. Harrison S. Textbook of Internal Medicine. PP. 2149-2152.
5. Hauser S. Hemochromatosis and the Heart. Heart disease and Stroke 1993; Vol 2: 487-489.
6. Wang TL, et al. Sick Sinus Syndrome as the Early Manifestation of Cardiac Hemochromatosis. Journal of Electrocardiology 1994; Vol 27, No 1: 91-96.
7. Rosenquist M, Hultcrantz R. Prevalence of a haemochromatosis among men with clinically significant Brady arrhythmias. European Heart Journal 1998; Vol 10: 473-478.
8. Miller M, Hutchins G. Hemochromatosis, Multi-organ Hemosiderosis, and Coronary Artery Disease. JAMA, July 1994; Vol 272, No 3: 231-233.
9. Click R, et al. Echocardiography and Systemic Diseases. J. Am. Soc. Echo 1994; Vol 7: 201-216.
10. Liu P, Olivieri N. Iron Overload Cardiomyopathies: New insights into an old disease. Cardiovascular Drugs and Therapy 1994; Vol 8: 101-110.
11. Scully R, et al. Case Records of the Massachusetts General Hospital. NEJM, August 1994; 460-466.

*Drs. Kazzaz, Kishan and Smith work in the department of internal medicine, UAMS Medical Center and the John L. McClellan Memorial Veterans Hospital. Drs. Kishan and Smith serve in the division of cardiology.*



# GAMMA KNIFE RADIOSURGERY: Brain Surgery Without a Scalpel.

The Gamma Knife Radiosurgery Center, now in full operation at UAMS, is a revolutionary noninvasive tool used to treat intracranial benign and malignant tumors, vascular malformations and certain functional disorders such as trigeminal neuralgia without a single incision. The Gamma Knife uses a concentrated radiation dose from Cobalt-60 sources to damage abnormal tissue while sparing adjacent normal tissue. This exactness is accomplished by 201 beams of

radiation intersecting to form a precise tool. These beams are focused on the target area destroying only that which is abnormal, while sparing adjacent, normal tissue from clinically significant radiation.

Treatment with the Gamma Knife is multidisciplinary. The skills of a neurosurgeon, radiation oncologist and physicist are brought together to develop a treatment program tailored to each individual patient.

## SAFE

The risk of surgical complications is greatly reduced because the Gamma Knife procedure is performed without an incision. Therefore, Gamma Knife radiosurgery is virtually painless. Patients routinely use only a local anesthesia with a mild sedative, thereby eliminating the problems sometimes associated with general anesthesia.

## COST SAVING

Conventional neurosurgery typically means a lengthy hospital stay, expensive medication and sometimes months of rehabilitation. The Gamma Knife reduces these costs greatly. Patients are usually able to leave the hospital the same day and resume their normal activities within a few days. Post-surgical disability and convalescent costs are typically minimal. At the same time, it provides patients with dramatically improved quality of life by avoiding post-operative complications such as hemorrhage and infection associated with conventional surgery.

## PROVEN

The success rate of the Gamma Knife is unprecedented. It has established clinical efficacy for many reported indications including obliteration rates in AVM's, and treatment success rates for acoustic neuromas, meningiomas and metastatic tumors. Close to 135,000 patients have had Gamma Knife radiosurgery with no mortality and minimal morbidity reported. Backed by over three decades of clinical experience and documented results. No other neurosurgical tool has met with such impressive results.

For more information on the UAMS Gamma Knife Center call Mark E. Linskey, M.D., Co-Director, Neurosurgery or Dennis Shrieve, M.D., Ph.D., Co-Director, Radiation-Oncology at 501/601-1800 or 1-800-942-8267.



*World Class Care*

UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES  
4301 West Markham / Little Rock, Arkansas 72205  
[www.gammaknife.uams.edu](http://www.gammaknife.uams.edu)

# Preventing Perinatal HIV: Prenatal HIV Testing and Strategies to Reduce the Risk of Maternal — Fetal HIV Transmission

By MICHAEL SACCENTE, MD

The transmission of human immunodeficiency virus (HIV) from infected mothers to their infants has declined dramatically over the past several years in the United States.<sup>1,2</sup> This favorable trend followed widespread implementation of the three-part zidovudine (ZDV, AZT) regimen evaluated in Pediatric AIDS Clinical Trials Group Protocol 076 (PACTG 076), which reduced the risk of maternal — infant transmission by nearly 70%.<sup>3</sup>

Obviously, measures directed at preventing perinatal transmission are not considered unless the pregnant woman is known to be HIV-infected. With this in mind, the U.S. Public Health Service (USPHS) recommended voluntary prenatal HIV testing and counseling in 1995.<sup>4</sup> This article reviews the rationale behind these recommendations with the goal of reminding health care providers about the benefits of prenatal HIV testing. Strategies used to reduce the risk of perinatal HIV transmission are summarized.

## HIV/AIDS in Women

As of Sept. 30, 1999, HIV (including AIDS) was reported in 4,529 Arkansans since 1983. Females comprise 19% of this total, and since 1995, females have accounted for approximately 23% of reported cases of HIV (including AIDS). The vast majority of cases occur among women of childbearing age, and heterosexual contact is the predominant transmission risk category for women. Black women are disproportionately affected; while only 16% of women in Arkansas are black, 57% of adult and adoles-

cent women with HIV (not AIDS) reported between 1995-1997 were black.

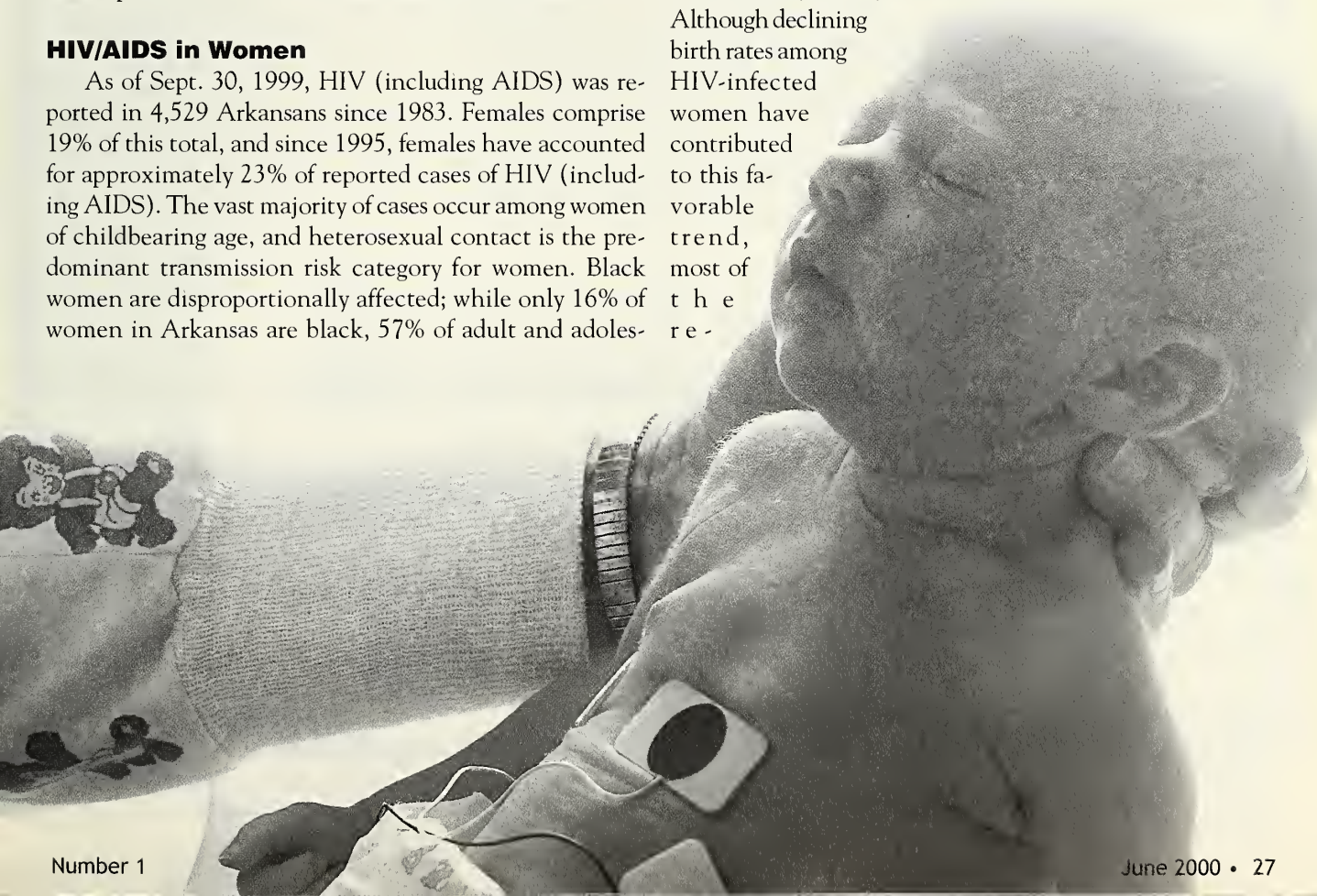
The epidemiology of HIV and AIDS among women in Arkansas resembles the national picture. Women accounted for 19% of the adult AIDS cases reported in the United States in 1995, and 57% of these women were black.<sup>5</sup>

Nationwide, HIV infection rates continue to rise among women of childbearing age, particularly adolescent racial minorities.<sup>6</sup> Compared to 1991 rates, the greatest increases in AIDS incidence rates in 1995 occurred among women residing in the midwestern and southern regions of the United States.<sup>5</sup>

## Trends in Perinatal HIV/AIDS

In the United States, perinatal AIDS cases peaked in 1992 (n=907), and subsequently decreased 67% between 1992-1997 (n=297).<sup>1</sup>

Although declining birth rates among HIV-infected women have contributed to this favorable trend, most of the re-





duction in the incidence of perinatal AIDS is attributable to other factors, the most important of which is maternal antiretroviral therapy.

From 1992-1997, a total of 135 infants were born to HIV-infected women in Arkansas. Seventy-three perinatally exposed infants were born during the 1995-1997 period, an increase of 20% compared to the 1992-1994 period. Among the total 135 exposed infants, 81 (60%) are not infected with HIV, 6 (4%) have asymptomatic HIV infection, 17 (13%) have AIDS, and 31 (23%) have been lost to follow-up or moved out of state.

### Reducing the Risk of Maternal-Fetal Transmission of HIV

The strongest predictor of HIV transmission from mother to infant is the maternal plasma HIV RNA level.<sup>7, 8, 9, 10</sup> The USPHS recommends that the same general parameters used in the management of nonpregnant HIV-infected patients should be applied to pregnant women.<sup>11</sup> In other words, one goal of antiretroviral therapy during pregnancy is sustained maximal suppression of the plasma HIV RNA level. Antiretroviral regimens used for pregnant women should include ZDV. In addition to antepartum antiretroviral therapy, intravenous ZDV is given during labor.<sup>12</sup>

Pregnant women who present for the first time late in pregnancy or in labor should be tested for HIV. Women found to be infected before delivery should receive a ZDV containing antiretroviral regimen. This approach, though not optimal, is supported by data that suggest that courses of ZDV shorter in duration than that used in PACTG 076 reduce the rate of transmission.<sup>13</sup>

Other strategies that target intrauterine and intrapartum transmission include limiting exposure of the infant to maternal blood and secretions (e.g. with cesarean section), treating conditions that might facilitate transmission and prophylactic antiretroviral therapy for the infant.<sup>14</sup>

Currently, only the last strategy can be recommended universally as a means to reduce maternal-fetal trans-

mission of HIV. Avoidance of breastfeeding reduces postpartum transmission.<sup>14</sup>

### Potential Benefits of Prenatal HIV Screening

In addition to providing the opportunity to interrupt perinatal transmission, prenatal HIV testing allows for the early identification and treatment of infected infants. Of course, women found to be HIV-infected may benefit from earlier treatment of their disease than would otherwise occur if they were not screened.

### Prenatal HIV Testing and Reporting in Arkansas

Arkansas law requires that every physician or other health care provider who attends pregnant women test each woman for HIV, syphilis and hepatitis B virus and provide counseling regarding the risks of transmission of these infections to her infant. If a patient refuses testing, this circumstance must be documented in the medical record. HIV is a reportable disease in Arkansas. When HIV infection is diagnosed in a pregnant woman, the health care provider has two options for reporting the case to the Arkansas Department of Health. The HIV/AIDS Case Report Form may be completed and sent to Jerry Mulloy, Pediatric Officer, 4815 W. Markham, Slot 33, Little Rock, AR 72205, or Mulloy may be called directly at (501) 661-2908. ■

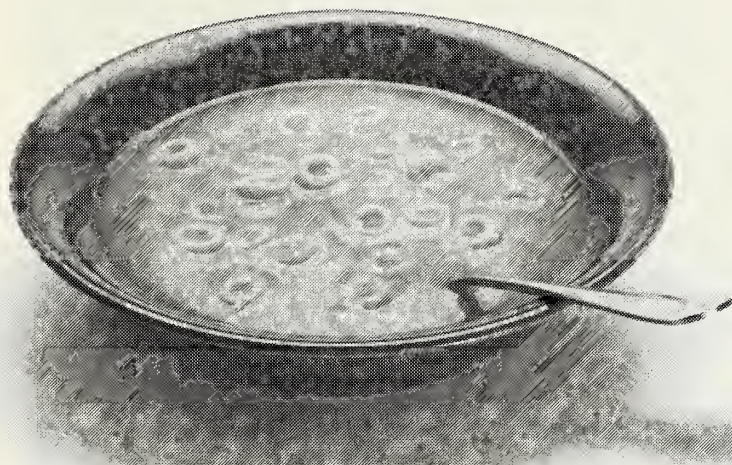
### References

1. Lindegren ML, Byers RH, Thomas P, et al. Trends in perinatal transmission of HIV/AIDS in the United States. JAMA 1999;282:531-8.
2. CDC. Update: perinatally acquired HIV/AIDS - United States, 1997. MMWR 1997;46:1086-1092.
3. Connor EM, Sperling RS, Gelber R, et al. Reduction of maternal - infant transmission of human immunodeficiency virus type 1 with zidovudine treatment. N Engl J Med 1994; 331: 1173-80.
4. CDC. U.S. Public Health Service recommendations for human immunodeficiency virus counseling and voluntary testing for pregnant women.

- MMWR 1995;44(no. RR - 7).
5. Wortley PM, Fleming PL. AIDS in women in the United States. JAMA 1997;278:911-6.
6. Mofenson LM. Can perinatal HIV infection be eliminated in the United States? JAMA 1999;282:577-9.
7. Dickover RE, Garratty EM, Herman SA, et al. Identification of levels of maternal HIV - 1 RNA associated with risk of perinatal transmission - effect of maternal zidovudine treatment on viral load. JAMA 1996;275:599 -605.
8. Sperling RS, Shapiro DE, Coombs RW, et al. Maternal viral load, zidovudine treatment, and the risk of transmission of human immunodeficiency virus type 1 from mother to infant. N Engl J Med 1996;335:1621-9.
9. Mofenson LM, Lambert JS, Stiehler ER, et al. Risk factors for perinatal transmission of human immunodeficiency virus type 1 in women treated with zidovudine. N Engl J Med 1999;341:385-93.
10. Garcia PM, Kalish LA, Pitt J, et al. Maternal levels of plasma human immunodeficiency virus type 1 RNA and the risk of perinatal transmission. N Engl J Med 1999;341:394-402.
11. CDC. Public Health Service Task Force recommendations for the use of antiretroviral drugs in pregnant women infected with HIV - 1 for maternal health and for reducing perinatal HIV - 1 transmission in the United States. MMWR 1998;47(no. RR-2).
12. CDC. Recommendations of the U.S. Public Health Service Task Force on the use of zidovudine to reduce perinatal transmission of human immunodeficiency virus. MMWR 1994;43(no. RR-11).
13. Shaffer N, Chuachoowong R, Mock PA, et al. Short - course zidovudine for perinatal HIV-1 transmission in Bangkok, Thailand: a randomised controlled trial. Lancet 1999;353:773-80.
14. Rogers MF, Shaffer N. Reducing the risk of maternal - infant transmission of HIV by attacking the virus. N Engl J Med 1999;341:441-2.

*Dr. Saccente is medical director for the division of AIDS/STD at the Arkansas Department of Health and assistant professor of medicine in the division of infectious diseases at the University of Arkansas for Medical Sciences.*

# We're chicken noodle soup for your health plan blues.



When you're feeling sick, the last thing you need is a health insurance headache. That's why more people are counting on QualChoice/QCA. We serve a bowlful of benefits that cures many health plan pains:

**A statewide network of over 3,300 quality doctors,  
Over 80 quality hospitals across the state,  
An OB/GYN as a second Primary Care Physician  
for females age 16 and older, and  
Friendly service from local, QualChoice/QCA employees.**

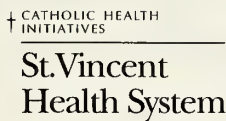
So if you're looking for a better health plan, choose  
QualChoice/QCA. Doctor's order!

## QualChoice/QCA

A B E T T E R H E A L T H P L A N

For more information call your broker or  
visit our website at [www.qcark.com](http://www.qcark.com).

NETWORK PROVIDERS INCLUDE





# Collect Bad Debt

- Cheaper
- Faster
- In compliance with the Law

**Collection Agency**



**Maggio Law Firm**

If you've always used a collection agency. . .WHY?

Cut out the middle man by retaining the Mike Maggio Law Firm.

Save time. Save money. Be in compliance with the law.

Have you always used a collection agency because "that's the way you've always done it?"

*Try a new way. . . tip the scales in your favor, call Mike Maggio today.*

## **MAGGIO LAW FIRM**

**your collection law firm**

2843 Prince Street, Conway, AR 72033 501-327-4340  
303 N. Spruce Street, Searcy, AR 72143 501-279-2769  
[www.ebaddebt.com](http://www.ebaddebt.com)

# PEOPLE+EVENTS

## HONORED

### Physicians Receive Awards from AMA

Each month the American Medical Association presents the Physician's Recognition Award to those who have completed acceptable programs of continuing education.

AMA recipients for January include Drs. Edward E.C. Angtuaco, Robert L. Fincher, Robert B. Kennedy, Robert L. Overacre and Carl V. Smith, all of Little Rock; Dr. Charles W. Craft of Greenwood; Dr. Theophilus A. Feild of Fort Smith; Dr. Thomas A. Langston of Harrison; Dr. Phuong C. Ly of Marianna; and Dr. Martha K. Morgan of Pea Ridge.



*Dr. Joseph M. Beck II, center, at the March awards dinner at the AMA National Leadership Development Conference in Miami.*

## Dr. Beck Completes Leadership Program

Dr. Joseph M. Beck II of Little Rock was one of 50 physicians selected to participate in the American Medical Association/Glaxo Wellcome Emerging Leadership Program at the AMA's National Leadership Development Conference March 26-28 in Miami. Dr. Beck is board certified in internal medicine and medical oncology.

The 50 practicing physicians attended a day-long, invitation-only pro-

gram, sponsored by Glaxo Wellcome, at the Fountainebleau Hilton Hotel. The leadership program is an intensive leadership development program emphasizing legislative advocacy. Those selected are generally in their early to mid-careers, have been in practice two years and have demonstrated leadership potential, commitment to leadership, participation in organized medicine and diversity of leadership experience.

## OBITUARY

### John D. Ashley Jr., MD

Dr. John D. Ashley, 84, of Newport, a retired internal medicine physician, died Feb. 22. Dr. Ashley graduated from Virginia Commonwealth University in Richmond in 1940. He became board certified in internal medicine in 1947 and was licensed to practice medicine in Arkansas in 1949.

#### Noor Kabani, MD

Specialty: IM  
1609 W. 40th Ave., #207  
Pine Bluff, AR 71603  
(870) 534-7585

#### James Lee Krupala, MD

Specialty: OTO  
1408 W. 43rd Ave.  
Pine Bluff, AR 71603  
(870) 535-5719

#### Zbigniew Kula, MD

Specialty: OBG  
203 Main St.  
Crossett, AR 71635  
(870) 364-3474

## New Members

#### Christopher A. Lamps, MD

Specialty: Resident - CHP  
1120 Marshall St., #654  
Little Rock, AR 72202  
(501) 320-5150

#### Carlene W. Lyle, MD

Specialty: P  
21 Bridgeway  
North Little Rock, AR 72113  
(501) 771-1500

#### Mark Malloy, MD

Specialty: IM  
909 Unity Road  
Crossett, AR 71635  
(870) 364-9111

#### Richard Nelson, MD

Specialty: DR  
P.O. Box 3887  
Fort Smith, AR 72913  
(501) 452-9416

#### Steven S. Orten, MD

Specialty: OTO  
6801 Rogers Ave.  
Fort Smith, AR 72913  
(501) 478-3540





## When we focused on heart care, the world focused on us.

They come here to see. And to learn. Heart specialists from places as far away as Poland, Germany, Taiwan, and Japan. And from cities around the country. They represent prestigious universities. And leading healthcare systems. They are physicians and researchers and hospital managers, the best the world has to offer. Yet they come to our hospital to see our facilities, our technologies, and to understand our procedures. Why? To learn how to be even better. If your patients had heart disease, could they come here too?

**ARKANSAS HEART HOSPITAL**  
*An entire hospital fighting heart disease*

1701 S. Shackleford Road • (501) 219-7000 • [www.arheart.com](http://www.arheart.com)

**Vijayabhasker Reddy, MD**

Specialty: FP  
107 Hickory Hill  
Helena, AR 72342  
(870) 338-8377

**Melanie Smith, MD**

Specialty: OTO  
2504 McCain Blvd., Suite 114  
North Little Rock, AR 72116  
(501) 758-9800

**Steven O. Smith, MD**

Specialty: ORS  
P.O. Box 17027  
Fort Smith, AR 72917  
(501) 709-7002

**William S. Sosebee, MD**

Specialty: OBG  
101 Skyline Drive  
Russellville, AR 72801  
(501) 968-2345

**Pattana Srinivasan, MD**

Specialty: Resident - AN  
4301 W. Markham St.  
Little Rock, AR 72205  
(501) 686-6114

**R. Todd Stewart, MD**

Specialty: IM  
6801 Rogers Ave.  
Fort Smith, AR 72903  
(501) 452-2077

**Michael D. Stout, MD**

Specialty: FP  
4202 S. University Ave.  
Little Rock, AR 72204  
(501) 562-4838

**Sachin Swarup, MD**

Specialty: Resident - FP  
510 Ondo Lane, #7D  
El Dorado, AR 71730

**Rudolph V. Tacoronti, MD**

Specialty: OM  
4951 Old Greenwood Road  
Fort Smith, AR 72903  
(501) 484-4665

**Charles H. Wagoner, MD**

Specialty: R  
P.O. Box 246  
Crossett, AR 71635  
(870) 364-9231

**James D. Waters, MD**

Specialty: AN  
620 N. Willow St.  
Harrison, AR 72601  
(870) 365-2071

# ADVERTISERS INDEX

AMS Benefits Inc. ....	Inside back cover
Arkansas Financial Group Inc., The .....	4
Arkansas Foundation for Medical Care .....	3
Arkansas Heart Hospital .....	32
Employers Healthcare Resources Inc. ....	9
Flake and Kelley Management .....	8
Freemyer Collection System .....	15
Gary Darwin, MD .....	9
Guest House Inn .....	14
Helena Regional Medical Center .....	22
Hutchinson/Ifrah Financial Services Inc. ....	17
Jones Daewoo of Arkansas .....	18
Little Rock Medical Association .....	14
Maggio Law Firm .....	30
Medical Center of South Arkansas .....	20
Medicus .....	13
Metropolitan National Bank .....	22
Millard-Henry Clinic .....	13
PhyAmerica Physician Services Inc. ....	20
QualChoice/QCA of Arkansas .....	29
Riverside Motors .....	6
St. Bernards Regional Medical Center .....	12
St. Paul Medical Services .....	21
Snell Prosthetic & Orthotic Laboratory .....	10
Southwest Capital Management Inc. ....	13
Southwestern Bell Wireless .....	Inside front cover
State Volunteer Mutual Insurance Co. ....	Back cover
University of Arkansas for Medical Sciences .....	26

Special Publications  
Publisher  
*Brigette Williams*

Special Publications  
Editor-in-Chief  
*Natalie Gardner*

Managing Editor  
*Judith M. Gallman*

Assistant Editor  
*Christy L. Smith*

Sales Manager  
*Stephanie Hopkins*

Assistant Sales Manager  
*Elizabeth Daniel*



**ARKANSAS BUSINESS PUBLISHING GROUP**

Chairman and  
Chief Executive Officer  
*Olivia Farrell*

President and Publisher  
*Jeff Hankins*

Director of Design & Production  
*Virgeen Healey*

Editorial Art Director  
*Irene Forbes*

Advertising Art Director  
*Jeremy Henderson*

Advertising Coordinator  
*Kristen Ebbing*

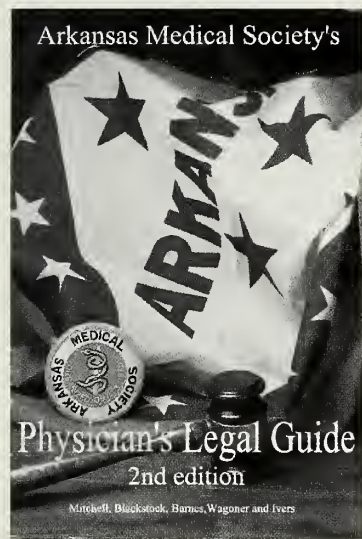
Marketing Assistant  
*Mitzi Tiffie*

Database Administrator  
*H.L. Moody*

Advertising Assistant  
*Steven White*

Executive Vice President  
*Sheila Palmer*

© 2000 Arkansas Business  
Publishing Group  
www.abpg.com



## 2nd edition Arkansas Medical Society's Physician's Legal Guide

Be one of the first to obtain this guide which contains a multitude of state and federal laws affecting the practice of medicine. This guide is a valuable resource for physicians, clinic and hospital administrators, office staff, attorneys, regulators and many others.

**\$87<sup>00</sup>**  
List Price

**\$65<sup>00</sup>**  
for AMS  
members

**A 25%  
Discount!**

(Prices include shipping and handling.)

Check enclosed in the amount of: \$ \_\_\_\_\_

Please charge my Visa or Mastercard:

Cardholder's name: \_\_\_\_\_

Credit card No.: \_\_\_\_\_

Exp. date: \_\_\_\_\_

Cardholder's Signature: \_\_\_\_\_

☐ Please check if you are  
an AMS member.

Name: \_\_\_\_\_

Clinic: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_ Fax No.: ( ) \_\_\_\_\_

**CREDIT CARD ORDERS  
CAN BE FAXED TO:  
(501) 224-6489**

**Call the AMS office at 501-224-8967 or 800-542-1058 for volume discount pricing.**





Top, left, Helena's Delta Cultural Center recently reopened with new exhibits. Top, right, the Confederate cemetery appeals to history buffs. Bottom, the King Biscuit Blues Festival brings thousands to the town each October.

Photos: A.C. Haralson/ Arkansas Department of Parks & Tourism

## Foxglove Bed and Breakfast

Revisit the turn of the century with a visit to the elegant Foxglove Bed and Breakfast in Helena.

The stunning mansion, built in 1900 by Elmer West and listed on the National Register of Historic Places, hunkers down on Crowley's Ridge overlooking the mighty Mississippi River and historic Helena. The home looks much as it did in its glory days — period antiques, parquetered floors, stained glass, fine oriental rugs, six original fireplaces, quarter-sawn oak and a double-seated staircase. But modern conveniences, namely private luxury baths and whirlpool tubs, give the B&B an added bonus of opulence. The home was largely unchanged until 1944 when conversion into a bed and breakfast was undertaken. Today it offers eight guest rooms.

Every visitor can find something entertaining in Helena, which is a Civil War battle site. Foxglove is within three miles of two casinos, and 10 more lie between Helena and Memphis, which is a short 60 miles north and home to Graceland, Elvis' palatial spread. Antiques shops are plentiful, as are historical sites, including the Phillips County Library and Museum and Confederate cemeteries. In May, the Delta Cultural Center reopened with new exhibits. Every October, Helena hosts the annual King Biscuit Blues Festival, the third largest blues festival in the world.

For more information about the Foxglove, contact John Butkiewicz, innkeeper, at 220 Beech St., Helena, 72342, (870) 338-9391 or (800) 863-1926. You can also visit the B & B on line at [www.bbonline.com/ar/foxglove](http://www.bbonline.com/ar/foxglove). ■



# Arkansas Medical Society Health Benefit Plan...



AMS BENEFITS, INC.

A wholly owned subsidiary of the  
Arkansas Medical Society

P. O. Box 55088

Little Rock, Arkansas 72215-5088

(501) 224-8967

WATS 1-800-542-1058

FAX (501) 224-6489

Ask about our other services including  
Professional Overhead, Disability  
& Life Insurance.



*tailor-made for physicians*

The Arkansas Medical Society Health Benefit Program is a health insurance plan designed exclusively for members of the Arkansas Medical Society. Underwritten by American Investors Life Insurance Company. Indemnity and managed care plans available. For information call (501) 224-8967 or 1-800-542-1058.





There's nothing fair about treating physicians like fair game

**S**ome folks seem to think that taking pot shots at physicians is just good clean fun. We couldn't agree less. For 25 years, the physicians who operate SVMIC have dedicated themselves to providing the very best protection possible against medical malpractice litigation. As doctors, we know just how dangerous and unfair the world really can be. And, with our unrivaled risk management programs, no one can do more to prevent a physician from ever finding himself in the line of fire, than SVMIC.

For more information, contact Susan Decareaux or Thad DeHart • P.O. Box 1065 Brentwood, TN 37024-1065  
e-mail: [svmic@svmic.com](mailto:svmic@svmic.com) • Web Site [www.svmic.com](http://www.svmic.com) • 1-800-342-2239 • (615) 377-1999





# THE Journal

OF THE ARKANSAS MEDICAL SOCIETY

Vol. 97 No. 2

July/August 2000



## 2000 Annual Session Special Issue



{ PATIENT'S SMILE }

**YOU LOSE A LOT WHEN YOU LOSE YOUR SIGHT. PREVENT DIABETIC BLINDNESS.**

AFMC encourages Medicare and Medicaid providers to refer their diabetic patients to an eye care professional for an annual dilated eye exam. For more information on the AFMC Health Care Quality Improvement Program, call **1-877-650-AFMC.**



*Arkansas Foundation  
for Medical Care*

Now you can afford to have a mid-30's crisis.



It's the best preemptive strike on middle-age yet. With a 185 hp Kompressor engine, the C230 also comes standard with features like the Electronic Stability Program, regular scheduled maintenance\* and 24-hour Tele Aid\*\* assistance, making for one sweet ride at an incredibly attractive price. You'll feel younger and a heck of a lot wiser too. **The C-Class, starting at \$31,750.<sup>†</sup>**




**Mercedes-Benz**

**Riverside Motors, Inc.**

1403 Rebsamen Park Road, Little Rock, AR (501) 666-9457

<sup>†</sup>MSRP for a C230 Kompressor at \$31,750 excludes \$645 transportation charge, all taxes, title/documentary fees, registration, tags, retailer prep charges, insurance, optional equipment, certificate of compliance or noncompliance fees, and finance charges. Prices may vary by retailer. \*As called for by the Flexible Service System. Wear items excluded. Limitations apply. See your Mercedes center for a copy of the Mercedes-Benz limited warranty and details of The Mercedes Maintenance Commitment. \*\*Tele Aid requires consumer subscription for monitoring service, connection charge, and air time. Available only in cellular service areas. First year's monitoring, subscription, monthly access fees, and 30 minutes of air time included at no cost. See retailer for details. For more information, call 1-800-FOR-MERCEDES, or visit our Web site, [www.MBUSA.com](http://www.MBUSA.com). AIR BAGS ARE A SUPPLEMENTAL RESTRAINT SYSTEM, SO REMEMBER AIR BAG SAFETY: BUCKLE EVERYONE AND CHILDREN IN BACK! © 2000 Authorized Mercedes-Benz Retailers





**A**voiding litigation is always a good idea. In fact, staying out of the courtroom permanently is one of the trickiest, most brilliant procedures you may ever undertake. SVMIC places a unique focus on keeping our policyholders where they belong, at their patient's side and not stuck in some courtroom. We employ a full-time staff of attorneys that are available to all of our policyholders, even before a problem ever arises. Along with an entire battery of unrivaled risk management programs, they can keep the fickle finger of litigation from pointing at you.



State Volunteer  
Mutual Insurance  
Company

For more information, contact Susan Decareaux or Thad DeHart • P.O. Box 1065 Brentwood, TN 37024-1065 • e-mail: [svmic@svmic.com](mailto:svmic@svmic.com) • Web Site: [www.svmic.com](http://www.svmic.com) • 1-800-342-2239 • (615) 377-1999

**We all deserve our day in court, unless of course we can avoid it.**



# THE Journal

OF THE ARKANSAS MEDICAL SOCIETY

Winner of the ASAE Excellence in Communications Award  
Annual Session Special Issue

## CONTENTS

### FEATURES

- 46 **AMS Annual Session Highlights**  
*A look at the stellar line-up of speakers from this year's meeting, plus pictures to commemorate the event.*
- 52 **A Look Back**  
*1999 was a banner year for the AMS, with the creation of a Long-range Planning Committee, set to help refocus the AMS' efforts over the next several years.*
- 55 **Shuffield Award Winner**  
*Rep. Marion Berry, D-Ark., is this year's winner of an award given to nonphysicians making a difference in the state's health care sector.*
- 56 **Fifty Year Club**
- 57 **Alliance Report**  
*Cynthia Weber is the Alliance's new president.*
- 59 **Report of the Council**
- 61 **Report of the House of Delegates**
- 62 **Long-range Planning Committee Report**
- 63 **Long-range Planning Committee Plan**
- 65 **Annual Session Sponsors**
- 68 **AMS 2000-2001 Officers**



Dr. Gerald Stolz assumed leadership of the AMS.  
— page 51



U.S. Rep. Marion Berry was named this year's Shuffield Award winner.  
— page 55

### DEPARTMENTS

- 45 **Letters to the Editor**
- 45 **What We've Done For You Lately**
- 66 **People + Events**



# Two of the best financial planners in the nation are in Arkansas.

**They can be found at  
The Arkansas  
Financial Group.**

Here's what the editors of  
*Worth* and *Medical  
Economics* had to say:

THE 300 BEST FINANCIAL ADVISERS

**Worth**

HOW TO  
**LIVE RICH**

Strategies for  
Getting All  
You Want  
Out of Life

Best 250 Financial Advisers

**Worth**

ANDY KOREN

**Marilyn  
& You**

Would you ever imagine a  
Woman's Quarterly magazine  
The Retirement Plan  
A Guide to Real Estate  
The Ultimate Guide to  
Strategies in Your Home  
Simplify Your Life with  
the Best of the Best  
A Guide to the Best of the Best

medical  
**economics**

★★★★★

**The 120 best  
financial  
advisers  
for doctors**

Our exclusive list

*"The Best 250  
Financial  
Advisers, 9/99"*

*"The Best 300  
Financial  
Advisers, 9/98"*

*"The Best 250  
Financial  
Advisers, 10/97"*

*"The 120 Best  
Financial  
Advisers for  
Doctors, 7/27/98"*

Since 1985, we've  
been helping busy  
people make smart  
financial decisions.  
So next time you're  
looking for objective  
answers to life's cru-  
cial financial deci-  
sions, call The Arkansas Finan-  
cial Group. You'll be in great  
company.

*"Fee-only, objective, customized,  
comprehensive, affordable advice"*

**The Arkansas  
Financial Group, Inc.  
376-9051**

**CINDY CONGER**  
MBA, CPA/PFS, CFP

**RICK ADKINS**  
MBA, CFP, ChFC



**COMMUNICATIONS COORDINATOR**

Judy Hicks

**EXECUTIVE VICE PRESIDENT**

Kenneth LaMastus, CAE

**ASSISTANT EXECUTIVE VICE PRESIDENT**

David Wroten

**EDITORIAL BOARD**

Jerry Byrum, MD	Pediatrics
Joseph M. Beck, II, MD	Oncology
Lee Abel, MD	Internal Medicine
Samuel Landrum, MD	Surgery
Jerry Kendall, MD	Family Practice
William Ackerman, MD	Anesthesiology

**EDITOR EMERITUS**

Alfred Kahn Jr., MD

**ARKANSAS MEDICAL SOCIETY**

**2000-2001 OFFICERS**

Gerald A. Stolz, Jr., MD, Russellville  
*President*

Joe Stallings, MD, Jonesboro  
*President-elect*

Paul A. Wallick, MD, Monticello  
*Vice President*

Lloyd G. Langston, MD, Pine Bluff  
*Immediate Past President*

Carlton L. Chambers, III, MD, Harrison/Little Rock  
*Secretary*

Dwight M. Williams, MD, Paragould  
*Treasurer*

Anna Redman, MD, Pine Bluff  
*Speaker, House of Delegates*

Kevin Beavers, MD, Russellville  
*Vice Speaker, House of Delegates*

Joseph M. Beck, II, MD, Little Rock  
*Chairman of the Council*

Established 1890. Owned and edited by the Arkansas Medical Society and published under the direction of the Council.

**Advertising Information:** Contact Stephanie Hopkins, P.O. Box 3686, Little Rock, AR 72203; (501) 372-2816.

**Postmaster:** Send address changes to: *The Journal of the Arkansas Medical Society*, P. O. Box 55088, Little Rock, Arkansas 72215-5088.

**Subscription rate:** \$30.00 annually for domestic; \$40.00, foreign. Single issue \$3.00.

*The Journal of the Arkansas Medical Society* (ISSN 0004-1858) is published monthly by the Arkansas Medical Society, #10 Corporate Hill Drive, Suite 300, Little Rock, Arkansas 72205. Printed by The Ovid Bell Press, Inc., Fulton, Missouri 65251. Periodicals postage is paid at Little Rock, Arkansas, and at additional mailing offices.

Articles and advertisements published in *The Journal* are for the interest of its readers and do not represent the official position or endorsement of *The Journal* or the Arkansas Medical Society. *The Journal* reserves the right to make the final decision on all content and advertisements.

Copyright 2000 by the Arkansas Medical Society.

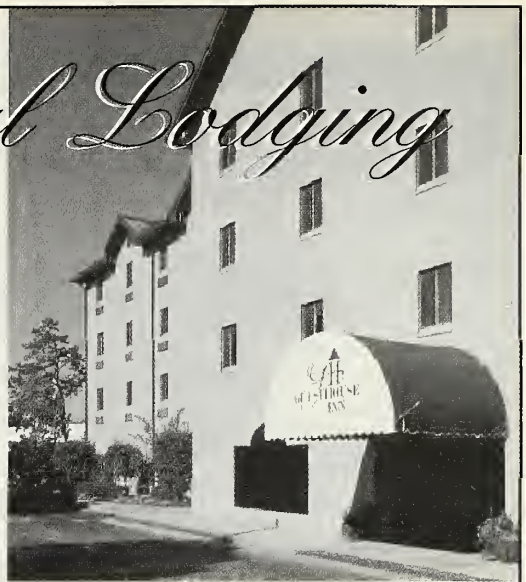
# Medical Lodging

Close proximity to all  
Little Rock hospitals

Serving Little Rock Visitors

- Medical stays
- Business travel
- Leisure travel

"Guesthouse Inn is your  
perfect home away from home  
while in Little Rock"



301 So. UNIVERSITY AVE. ▲ LITTLE ROCK, AR 72205 ▲ (501) 664-6800

## Let Us Hear From You!

**You can now E-mail AMS  
at the following addresses:**

Main address: [ams@arkmed.org](mailto:ams@arkmed.org)  
Ken LaMastus: [klamastus@arkmed.org](mailto:klamastus@arkmed.org)  
Lynn Zeno: [zeno@arkmed.org](mailto:zeno@arkmed.org)  
David Wroten: [dwroten@arkmed.org](mailto:dwroten@arkmed.org)  
Kay Waldo: [kwaldo@arkmed.org](mailto:kwaldo@arkmed.org)  
Journal: [journal@arkmed.org](mailto:journal@arkmed.org)

**Plus. . .**

We now have a web site.

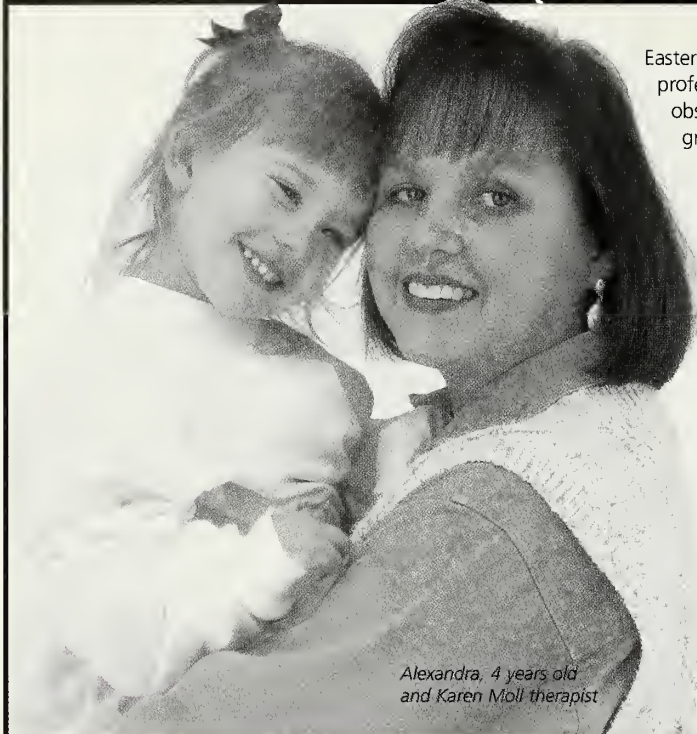
Come visit us soon at:

[www.arkmed.org](http://www.arkmed.org)





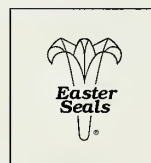
# The Staff of Life



Alexandra, 4 years old  
and Karen Moll therapist

Easter Seals is an astonishing range of services, programs and professional caregivers whose common goal – and uncommon obsession – is helping children and adults with disabilities gain greater independence.

With more than 35 years of experience in the evaluation and treatment of children with disabilities, Easter Seals' evaluation team is one of the most experienced in the state. We also provide hospital to home monitoring services for infants, inpatient and outpatient pediatric therapies and preschool services. If we can help a child you know, call our **Outpatient Referral Line at 1.877.533.3600.**



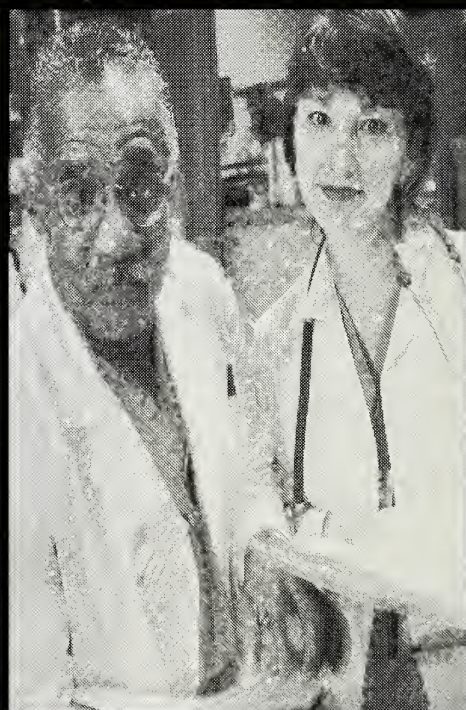
*Creating solutions. changing lives.*

3920 Woodland Heights Road  
Little Rock, AR 72212-2495  
501.227.3600 • [www.arkeasterseals.org](http://www.arkeasterseals.org)

## HEALTHY WEALTHY & WISE.

*Financial  
strategies  
specifically for  
physicians.*

At Hutchinson/Ifrah,  
we understand the issues  
that put a physician's practice  
and personal assets at risk.  
But our idea of being healthy,  
wealthy and wise is more than  
simply saving on taxes and  
protecting your assets,  
it's about maximizing your  
investment potential and  
planning for a tax-free  
retirement. Give us a call at  
**501/223-9190** and let us show  
you how we can help physicians  
achieve a healthy bottom line.



WE REALIZE YOUR POTENTIAL.

12511 Cantrell Road • Little Rock, Arkansas 72223  
(501) 223-9190 • 800-635-9985  
[www.hutchinson-ifrah.com](http://www.hutchinson-ifrah.com)





## LETTERS

I read with interest the commentary by Dr. Jerry D. Byrum in the May issue of the *Medical Journal*. I think he expressed well the many problems that exist today in the use of technology and the various ways that it touches the physician in the active practice of medicine. I also share his concern that the communication that existed formally between physicians and the camaraderie that was often found around the "coffee table" is no longer evident, which may be good but certainly is a departure from the past.

The communication that he did not touch upon is the one that I hear most neglected. The complaint that seems to emanate between physicians and patients is that the doctor "used no words with me," "he communicated very little," "spent very little time with me" and "I can't get anyone to speak to me over the telephone regarding my problem."

Hopefully, the many electronic devices that are present today may eventually be used for better communication between physicians and patients. All of these innovations are wonderful but there is nothing yet comparable to the physician conversing with the patient face to face, and physicians taking time to spend with his colleagues or referring physician.

W. Ray Jouett, MD  
Medical Director,  
National Comp. Care Inc.

Submit letters to the editor to  
[journal@arkmed.org](mailto:journal@arkmed.org) or by faxing  
(501) 224-6489.



## House Adopts Action Plan for Future

By DAVID WROTEN

**T**he full text of the AMS Long-range plan adopted in May by the House of Delegates can be found on page 63 of this issue of *The Journal*. I urge you to study it carefully and look for ways YOU can become involved in carrying out its action plans.

The plan represents the work of more than 100 physicians during the past year. Throughout all of the meetings and discussions there were several major issues or themes that permeated the room — technology, communication, membership and governance.

### Technology

If you are not on the information superhighway, prepare to get left behind — way, way behind. It is not too late to jump on but time is running out. The challenge for the AMS is to maximize the use of Internet-based technology while not ignoring the needs of our members who have yet to embrace its use. Look for major improvements in the AMS web page, including a members only section, online registration, bulletin boards and online access to continuing medical education.

### Communication

The most profound observation to come from the past year's efforts is the need to improve AMS communication strategies, mostly between the AMS and its membership. The Society publishes newsletters, alerts, this journal and other targeted material on a regular basis. Staff and physician leaders are frequent speakers at county medical societies and state specialty society meetings. Yet, throughout the planning process, volunteers made suggestions for proposed activities only to find out that the AMS was already doing them. The message of what the AMS does is not getting out to the membership effectively.

As a result, a special task force will be appointed to recommend improved communication strategies. How can members appreciate the value of their

Society if they don't know what it is we do? We must change this.

### Membership

The lifeblood of any organization is its membership. The AMS has a strong membership base. However, we must respond more rapidly to the changing demographics of the physician community. Generation Xers are driven by different values and wants than baby boomers. Employed physicians have different needs than physicians who own their practices. Fifty percent of medical students are women. These changes must be recognized, and the AMS must be willing and able to make changes to ensure that all physicians realize the value and benefit of their Society. A new membership committee will be developed to guide the AMS response to this challenge.

### Governance

The organizational structure of the AMS was developed during a time when the county medical society was the focal point of physician involvement and leadership. Times have certainly changed. You can count the active county medical societies on one hand. There must be avenues and opportunities for physicians to develop their leadership skills (as opposed to their medical skills). The AMS must ensure that these opportunities and avenues are available to physicians to provide for future leaders of the Society. As old avenues close, new ones must open. The AMS will appoint a task force to review the current avenues of participation and recommend changes to meet the needs of today's environment.

The message is simple. The AMS exists for one reason and that is to represent the physicians of Arkansas. The mission as stated in the long-range plan says it very succinctly — to serve as the voice of Arkansas physicians. The groundwork has been done by 100 of your colleagues. Your elected leaders and staff will work tirelessly to make sure the mission is achieved. Maybe it's time you stepped forward and said, "I'm proud to be a physician, how can I help?" ■



# 2000 Arkansas Medical Society Annual Session



*Clockwise from top left, Dr. James Sheridan, left, of Piggott won the \$1,000 travel certificate from AMS given away at the annual meeting. Dr. Lloyd Langston, AMS 1999-2000 president, inducts AMS' new president, Dr. Gerald Stolz. Dr. Joe Stallings is congratulated on his new president-elect position. The expo of sponsors was a highlight for AMS members at this year's meeting. Dr. Lloyd Langston, past president, Glenda Langston, Judy Stolz and Dr. Gerald Stolz, president.*





# Learning from the Experts

## Professionals Address Current Issues at AMS Session

By Judith M. Gallman

*The educational portion of the 2000 Annual Session covered topical issues covering broad territory.*

*Subjects included medical discoveries in space, gene therapy, joining a group practice or partnership, overuse of antibiotics, handling weapons of mass destruction and applying the Internet to health care.*

*The meeting was in Little Rock on May 5-6 at the Embassy Suites Hotel. Here are highlights from presenters who participated in the session's programs.*

### Onward to Online

Dr. Richard F. Corlin, speaker of the House of Delegates for the American Medical Association and a gastroenterologist in Santa Monica, Calif., spoke to the AMS' House of Delegates meeting May 5. He advised physicians about how they can use the Internet to deliver efficient, quality health care.



Dr. Corlin

The U.S. health care sector is a complicated industry but the Internet is making that even more so. The latest figures, Dr. Corlin said, indicate 68 percent of adult Americans get health information online — two out of three adults and growing. Of the 60 million adults who used the Internet last year, 91 percent said they found the information they wanted, he said.

With so many people online, more patients are becoming better informed about their health, but that also means many are probably getting harmful information posted by amateurs, he said.

The easy way to solve this is to have more physicians online providing information to patients. Some physicians have been reserved about computers in general, not to mention the Internet. But there are good reasons physicians should make the leap:

- More physicians and clinics are coming online.

- The Internet is full of resources that can help an individual or group practice.

- With the Internet, physicians can strengthen their relationships with patients by channeling patients' questions to their web site or by using their Internet-prompted questions to create better counseling and treatment.

- Physicians need to be the managers of health information online vs. amateurs who are developing dot.coms on a whim.

- It's easy for physicians to make the leap online because the AMA has already taken the steps to maximize patient care and minimize physicians' learning curve.

The AMA, in conjunction with Intel, has created the Internet Health Roadshow, a basic training program for physicians that has traveled to national and local AMA meetings and has gotten rave reviews. Also, the AMA's web site at [www.ama-assn.org](http://www.ama-assn.org) is easy to use and offers many resources, including back issues of JAMA and AMNews. And even more important, the AMA and its Online Oversight Panel have created guidelines for physicians to use when communicating with patients via e-mail.

Another step in the right direction is Medem Inc., a consumer web site created by the AMA and six national specialty societies. Medem stands for "medical empowerment." The site offers peer-reviewed health information for consumers. For physicians, it now offers "Put Your Practice Online," which allows physicians to create and publish a web site for their practice. The seven organizations that started Medem are in discussions with 22 other specialty societies who want to be a part of this new web site.

And for the issue of credibility and authenticity on the web, the

AMA, along with Intel, has developed "Digital Credentialing and Authentication Services." Both groups have identified a need for digital certificates for physicians to ensure that patient privacy and confidentiality are always protected. This service will be sold to health care-based Internet companies interested in providing secure solutions for their web sites. A digital certificate identifies individuals on the Internet, providing a reliable technique to verify authenticity that is better than a password or previously secure Internet techniques.

With all these systems in place and growing, physicians can be assured that getting — and staying — on the Internet can be secure, while enhancing office management and patient care.

### Space Traveler

Dr. M. Rhea Seddon, a general surgeon and chief medical officer of Vanderbilt Medical Group in Nashville, Tenn., is a former astronaut with



Dr. Seddon

more than 722 hours in space on three separate space missions. She is a former emergency department physician and a former National Aeronautics and Space Administration advisor. In Little Rock, she spoke about her NASA experiences, focusing on the medical and life sciences research she performed in space.

Dr. Seddon helped attendees understand how space experiences are applicable in the disease process here on earth.

Astronauts often experience an accelerated form of osteoporosis, much like the conditions present in the elderly population, she said. They also may develop a form of anemia, and a lot of body systems — muscles, for instance — quickly get out of shape in the absence of gravity. The conditions



# PHYSICIANS

**Air Force Healthcare.**

**Good Pay.**

**Professional Respect.**

**Why Do You Think We Say "Aim High"?**

Experience the best of everything.  
Best facilities. Best benefits.  
Outstanding opportunities for  
travel, 30 days vacation with pay,  
training and advancement.

For an information packet call

**1-800-423-USAF**

or visit [www.airforce.com](http://www.airforce.com)  
You'll see why we say, "Aim High."



**You can care  
for your patients  
while we take care  
of business.**

*Discover the benefits of ESA's  
integrated business services for  
healthcare professionals*

- **Payroll Services**  
- complete payroll management
- **Human Resources**  
- regulatory compliance management
- **Comprehensive Benefits Package**  
- health, dental, vision, 401K
- **Customized Consulting Services**  
- Employee Selection & Training  
- Ensure you have the right team  
- Budgeting and Planning  
- Develop a business plan that works for you.  
- Billing - Turn key service.



(501) 225-7300 • 1-800-344-5551

easily reverse once the astronauts are back on the ground.

Space studies, she said, may some day provide physicians with clues about how the body adapts to certain conditions, though more research is required. Research will be more useful once a full-scale space station lab can be permanently established, she said. That way, researchers could test whether treatment on earth will work similarly in space.

Dr. Seddon said Arkansas physicians were especially curious about and interested in the everyday practice of medicine and the use of equipment in space. Simple procedures — CPR, for instance — are infinitely more complicated in weightless situations, she said.

## Before You Sign

James P. Freiburg is a lawyer with Weil Freiburg a Chicago-based general practice law firm with an emphasis in health care issues.



Freiburg

He offered advice to young physicians and others about key points to keep in mind when joining a group practice or partnership.

He said practitioners should determine what type of working environment they want, factoring in issues such as geography and the type of practice — a private group, an institutional employer such as a hospital or a teaching and research center — in decision making.

Those who opt for a private group must decide whether a small group, middle-sized group or large group is preferable. In a small group, a newcomer might be asked to join as an owner immediately, possibly thrusting the newcomer into a position of management very early. In mid-size firms, the physicians may wonder whether they'll ever be an owner of the practice. In a large practice, it might take years to meet all the partners.

"There's nothing inherently good or bad about any of this. The question to answer is, 'Where would I be the happiest?'" Freiburg said.

He also urged physicians to visit

At the  
**HEART**  
of quality  
health care...



...there's  
**HealthLink.**

**HealthLink of Arkansas  
is proud to offer:**

- Convenient service
- Strong multi-payor distribution channel
- Flexible health care programs
- Well-established regional network
- Responsive local presence

**Join HealthLink Today!**

**1-877-284-0101**

**HealthLink  
of Arkansas**



Managed Health Care

prospective employers and to decide whether they'd like working in that setting without considering compensation.

"Compensation is an important [consideration], but the first order of business would be to make sure you would enjoy working in that setting," he said.

Candidates should tour the employer's facility, inspect equipment, look at other employees and quiz younger physicians to see what they think of the practice, Freiburg said. Newcomers should tour the hospitals where they'll be rendering services and take time to learn about the community.

"When it does come time to talk contract, use a check list," Freiburg said. "Make sure you cover everything on the list."

That list, Freiburg said, should cover base compensation, bonus compensation, scope of duties (including the number of offices and hospitals you may have to serve), the terms of your employment (including call and coverage issues), a moving allowance, medical health insurance, continuing medical education allowances, paid time off and retirement plans.

Another key point, Freiburg said, is to find out the likelihood of becoming an owner or partner, including a time frame, estimated cost and system of payment.

And, finally, Freiburg said, carefully consider the restrictive covenant provisions of the contract as well as exceptions that may be built in that might allow some relief from the restrictive covenant. The most common is prohibiting a departing physician from practicing medicine within a specific geographic location for a specified time. This effectively prevents a departing physician from establishing a practice with an established client base. Astute physicians can build in exceptions that require lifting such restrictions, especially in a case in which a practice fails to offer a doctor a partnership.

"Professional help is not inexpensive, but the career move you are about to make may be the most important career move you're ever going to make. It is important that you do it right."

## Looking for a Few Good Docs.

Exclusive positions are available in Arkansas and nationwide for physicians in many disciplines. Our fees are fully paid by the employers. All information is strictly confidential. Call today for a FREE consultation.

**Medicus**  
RESOURCE GROUP



1-800-394-4007  
501-228-4649  
501-228-5746 Fax

650 South Shackleford Rd., Suite 400  
Little Rock, AR 72211  
e-mail: medicus@medicusrg.com

## Growth of Your Retirement Investments Is Our Specialty

SEP IRAs  
IRA Rollovers  
401Ks

Using  
**The Optimum  
Performance Strategy  
TOPS**

The Unique Investment  
Program Developed by  
Tom Schallhorn.



**SOUTHWEST CAPITAL  
MANAGEMENT, INC.**  
REGISTERED INVESTMENT ADVISOR

Thomas N. Schollhorn, President  
501.374.1119 • 1.888.440.9133  
105 West Capital Avenue, Suite 101  
Little Rock, AR 72201-5732

## SERVING ARKANSAS' HEALTHCARE INDUSTRY

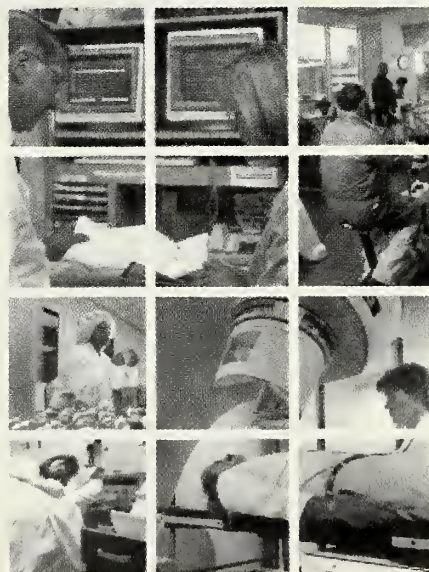
**WHEN YOUR INSURANCE NEEDS ARE UNIQUE,  
YOU WANT AN AGENT AND INSURANCE  
COMPANY THAT THINK LIKE YOU DO—  
INDEPENDENTLY**

Let's face it: not every insurance company will have the right insurance choices for the unique needs of the health care industry in Arkansas.

Hoffman-Henry doesn't work for any insurance company. We work for you. And our obligation is to help you find the right policy for your needs. From the right company. At the right price.

When it comes to independent thinking for the Arkansas medical community, we recommend St. Paul Fire and Marine Insurance Company. They specialize in the health care industry and will work closely with us to meet your unique insurance needs.

Call one of our three locations for a free review and consultation—before your current coverages expire.



**Hoffman-Henry**  
Insurance Corporation



**The St Paul**

*It pays to make the independent choice.*

Little Rock 501-224-8884 • Pine Bluff 870-534-4532 • Searcy 501-268-3528



# MEDICAL OFFICE SPACE

**DOCTORS BUILDING**  
500 South University Avenue  
Little Rock, Arkansas

Suites Available ranging from  
950 sq. ft. to 4,807 sq. ft.

Professional Management  
Maintenance 24 hours a day, 365 days a year  
Nightly janitorial service plus Day Maid  
Free Doctors Parking Lot -  
Or Low Cost Reserved Parking  
Free Use of Well Appointed Conference/Club Room  
Ancillary Services in Building

**Location convenient to all area Hospitals**  
including Baptist, St. Vincent Doctors,  
St. Vincent Infirmary, UAMS, VA  
and Arkansas Children's.

**CONTACT**  
**Betty Garcia - 664-1812**  
VISIT OUR WEBSITE [www.lrma.com](http://www.lrma.com)

## About Antibiotics

Dr. Chesley Richards is a board-certified internist and epidemiologist with the Hospital Infections Program at the Centers for Disease Control. He spoke in Little Rock on the over-use of antibiotics, prescribing a 12-step program for more effective usage.



Dr. Richards

"The major point we want to make is that antimicrobial resistance is a public health issue," Dr. Richards said. As antimicrobial resistance increases, there are fewer effective agents available for treating infection, he said.

But physicians can help remedy the problem in several ways.

First, they should use all available vaccinations and immunizations so that patients won't be as susceptible to certain infections. Also, doctors should strive to remove indwelling devices (urinary or intravenous catheters) from patients as soon as possible, reducing the risk of infection.

Physicians should be certain they are really treating an infection. Getting appropriate microbiological cultures from outpatients or nursing home patients is extremely difficult, so appropriate interpretation is difficult. Occasionally cultures read positive for bacteria but the bacteria does not represent a real infection.

If a clinician determines an infection does exist, the clinician must treat it as narrowly as possible. Treatment includes educating patients to continue taking antibiotics for an appropriate treatment period so that the infection is cured, surpassing the tendency to stop when they feel better after a couple of days.

"We need to make rules, especially in the hospital setting, that infectious guidelines be used and patients be isolated when appropriate," Dr. Richards said.

"And I think finally, most important, is that we all — all health care professionals, nurses and interns, residents, doctors and pharmacists — should wash our hands before seeing

## ACHIEVING SUCCESS ENTITLES YOU TO PRIVILEGES IN LIFE

Achieving your personal goals often requires a planned balance of financial management, including checking, loans, trust, investment products\* and services.

At Regions, we offer Private Banking to complement your success. We provide a level of service to efficiently meet your needs and maximize your valuable time. Whether you require business or personal services, you can rely on one of our private bankers to help ensure your goals are met by provided uncompromising, convenient service. To find out more about the special attention you deserve, please call us today.

Contact our Private  
Banking Department  
371-6613

**PRIVATE  
BANKING**

**Regions Bank**

[www.regionsbank.com](http://www.regionsbank.com)



\* Investments purchased through Regions Investment Company, Inc. are not deposits of the bank or guaranteed or insured by the bank, the FDIC or any government agency. Investments can assume risk including loss of principle. Regions is a member of NASD and SIPC.

MEMBER  
FDIC

patients and after the patient contact has occurred."

### **Destructive Weapons Assistance**

Lt. Col. Richard Swan, director of military support for the Arkansas Army National Guard, enlightened AMS members on government programs designed to handle weapons of mass destruction. Such weapons include conventional bombs, nuclear bombs, radioactive material and biological weapons and substances or chemical warfare.



Lt. Col. Swan

Recently the federal government has created teams whose duties are to assist with the aftermath of mass destruction, Swan said. The highly qualified teams, trained in specialty areas of weapons of mass destruction, will advise and assist the responders who arrive first on such scenes. They'll be responsible for cleaning up after the fact, much like the guard helps now with natural disasters. The Arkansas Army National Guard is in the process of selecting its team, whose members will be required to complete a year of specialty training, Swan said. Team members will understand how to use a mobile analytical lab as well as a unified command sweep. The first device will allow teams to identify "every substance known to man" in an instant, while the second device permits contact via every imaginable communication spectrum, Swan said.

### **Gene Therapy**

Dr. Nikhil Munshi, a research physician at the University of Arkansas for Medical Sciences, spoke on gene therapy at the annual session. Dr. Munshi has been director and chief of the Clinical Gene Transduction Laboratory at the Molecular Oncology and Gene Therapy, Myeloma and Transplantation Research Center at UAMS since 1996.



Dr. Munshi

# Taking the Helm

## *Dr. Gerald Stolz Wants to Continue AMS' Progress*

*At the AMS' 124th Annual Session, Dr. Gerald Stolz Jr., a Russellville pathologist, was inducted as the 2000-2001 president. Here are a few highlights from a recent interview with the new president.*



Two of Dr. Stolz's goals: addressing the needs of the new physicians who are joining the society's fold and making sure that women and minorities are well represented in the society. He hopes AMS' older members will assist him in encouraging young physicians to join the society. Many of these young physicians are joining group practices and will need an organization that is representing them, he said.

"We must respond to the needs of younger physicians; they will determine the future of the society.

"I want to reach out to women and minority doctors, embrace them and bring them into our group as active, participating members who know they have an important contribution to make to the society."

Dr. Stolz plans to watch the wave of managed care in the state, too.

"We do not have the critical population masses outside of the Little Rock area to let managed care function the way it wants to function. We are a very rural state,

and we don't have the critical population masses outside of Little Rock and northwest Arkansas that capitation will work in.

"I'm optimistic about the future

for Arkansas physicians. I think we will continue to see [preferred provider organizations] and other payers try to get more and more discounted fees for services ... but my opinion is that managed care per se is pretty well peaked in Arkansas."

While he'll be busy with AMS work, Dr. Stolz says he'll make sure to take time to relax. He and wife Judy enjoy spending time near the water at Greers Ferry Lake and Captiva, a southwest Florida island. The Stolz family also are big Arkansas Razorback fans and often trek to Fayetteville and Little Rock for games.

"Captiva is really a well-kept secret. It's not crowded at all. The beaches are beautiful, and it's amazing the number of fine restaurants that are crowded into that one little area.

"I'm use to continuous travel. It just comes with the territory."

Dr. Munshi has written many articles on cancer treatment, investigational new drugs, virology, bone marrow transplantation and experimental hematology. He received his medical degree and residency training from

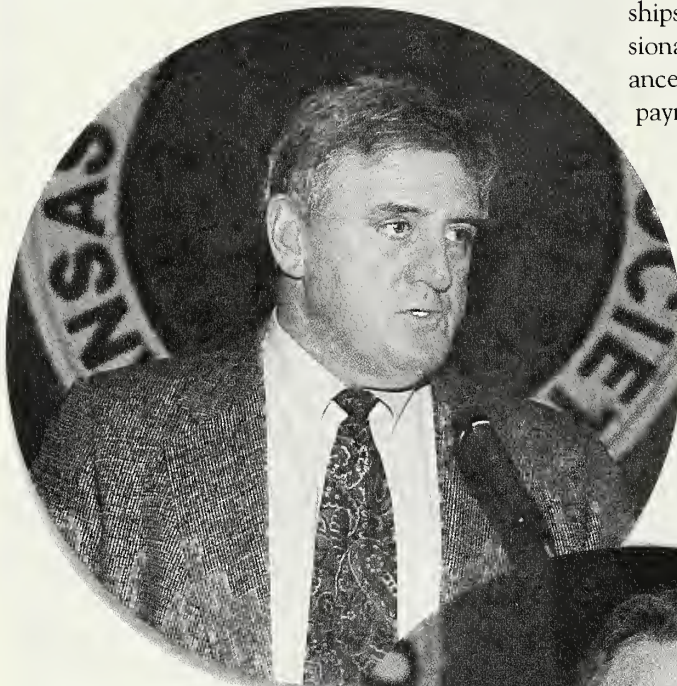
MS University in Baroda, India. He was a fellow in oncology at Johns Hopkins Oncology Center in Baltimore and a fellow in hematology/oncology at Indiana University School of Medicine in Indianapolis. ■



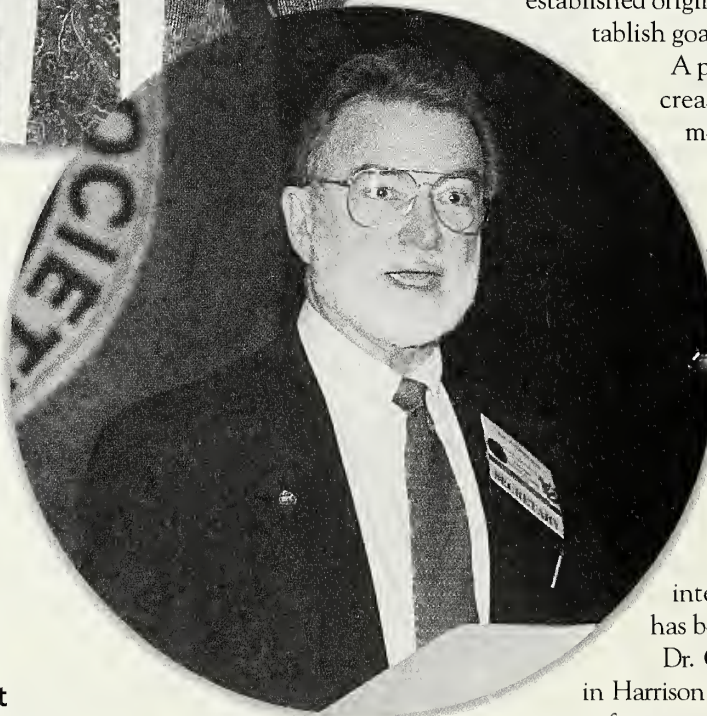
# 1999 was a Year to Regroup and Refocus

## *Progress Promising on Long-Range Planning Committee*

By Judith M. Gallman



**Dr. Lloyd Langston (top), past president, and Dr. Carlton Chambers, co-chairman of the Long-range Planning Committee, helped develop goals for AMS that will include more of the state's physicians.**



The year 1999 was a good one for the Arkansas Medical Society.

"I think everything went real well," said Dr. Lloyd G. Langston, AMS past president. "There was no major controversy in the society, and we had a number of successes politically. I believe we improved benefits for our members. We tried to open the door, to get in better contact with our members."

At the same time, the society continued developing relationships with political candidates, legislators and Arkansas' congressional delegation while initiating talks with the Arkansas insurance commissioner and managed care providers on the prompt payment debate.

And, probably most important, the society redoubled efforts to increase AMS membership.

"We want every physician in the state who works to feel like they have a place and we are speaking for them," Dr. Langston said. "Unity and inclusion [are] the key. And we're making some real progress."

Much of that progress, he said, has derived from the recent hard work of the reestablished Long-range Planning Committee.

An otolaryngologist from Pine Bluff, Dr. Langston asked a good friend, Dr. Carlton C. Chambers III, also an otolaryngologist, to help lead the committee, an ad hoc group established originally to study the society and establish goals.

A primary objective has been to increase AMS membership. Lagging membership is a common problem for many professional groups, both doctors said. The society wants to increase membership 15 percent by 2003 and has ideas how to do so, including becoming more user friendly, establishing a product or service referral system for physicians and customizing the AMS web site with exclusive members'-only offerings.

"We stimulated a great deal of interest," Dr. Langston said. "Carl has been the real workhorse."

Dr. Chambers, AMS secretary, lives in Harrison and Little Rock and is an assistant professor at the University of Arkansas for Medical Sciences. He immersed himself in the Long-range Planning Committee duties, serving as the committee co-chairman.

"We can't sit and be complacent," he said. "We must reevaluate who we are and where we are and where we want to go. If we



can come up with that, that's our long-range plan."

Dr. Chambers, through the committee, polled 100 volunteer members for opinions then had consultant Mary F. Dillard of Little Rock, president of Dillard & Associates Inc., facilitate two meetings to identify issues and concerns for a steering committee to undertake, ultimately deciding on six goals and strategies.

"She did a masterful job of bringing these renegade doctors into line," he said.

Dr. Chambers said it's imperative for the society to relate each issue to what is really going to be good for people, and that's the context from which the goals were established. They are to:

- Provide leadership in developing health care policy.
- Increase member involvement in AMS programs and activities.
- Improve AMS' organizational strength.
- Strengthen the role of AMS as an advocate for physicians and patients.

• Position the AMS as the leader in providing education and assistance to members.

• Produce a 15 percent increase in membership by 2003.

The goals and strategies were accepted by the AMS House of Delegates at the annual session, and the executive committee was directed to abide by the plan through the appointment of three committees whose duties will be to promulgate the covenants, Dr. Chambers said.

"We are now in the process of polling the membership for volunteers for the key committees," he said, identifying those as relating to membership, communication and governance. "These areas were determined to be the most important issues."

The society seems to be on track toward strengthening the organization. In fact, the new AMS president, Dr. Gerald A. Stolz Jr. of Russellville, has said he wants to recruit more women and minority members as well as younger physicians to make the society more inclusive.

"I will commit myself to doing the best job possible for physicians in the state of Arkansas and represent their interests as well as I can ... but I also want Arkansas physicians to be [involved] at the top level, making things happen for the society," Dr. Stolz said.

Two of his biggest goals are addressing the needs of the new physicians who are joining the society's fold and making sure that women and minorities are well represented in the society's ranks.

"I want to definitely continue the work of the strategic planning committee because we are getting more and more younger physicians involved in the council," he said. "Approximately 50 percent of the graduates of medical schools across the United States are now women and minorities. The profession is changing."

"The Medical Society has been a white, male-dominated society; we are making really sincere efforts to make it as open as possible," Dr. Chambers agreed. "The concept is to involve everybody." ■

## Get Published...

Give something back to your profession, write an article for

**THE Journal**  
OF THE ARKANSAS MEDICAL SOCIETY

*The Journal* needs your thoughts and ideas. So why not consider putting your expertise and experience on paper?

The Arkansas Medical Society is a statewide organization that represents all physicians, regardless of location or type of practice. The result is a statewide network united for the common good of the medical profession. The staff of the Arkansas Medical Society provides members with the best information and services available.

For information about submitting an article to *The Journal of the Arkansas Medical Society*, see information for Authors on the contents page of this issue or call Judy Hicks at 501-224-8967 or 1-800-542-1058.



### Central Arkansas Board Certified Emergency Medicine Physicians

#### ARE YOU TIRED? ARE YOU LOOKING TO SLOW DOWN?

We need you in our soon to be renovated 11,000 volume ED in Central Arkansas. BC Emergency Medicine staff physicians and a Medical Director are needed. Remuneration is \$100.00/hr, procured malpractice and Independent Contractor Status. Please contact Traci Mahlmeister with PhyAmerica at 800-476-5986, fax CV to 919-382-3274. All inquiries are confidential.



**PhyAmerica**  
Physician Services, Inc.



# Collect Bad Debt

- Cheaper
- Faster
- In compliance with the Law

**Collection Agency**

**Maggio Law Firm**



If you've always used a collection agency. . . WHY?

Cut out the middle man by retaining the Mike Maggio Law Firm.

Save time. Save money. Be in compliance with the law.

Have you always used a collection agency because "that's the way you've always done it?"

*Try a new way. . . tip the scales in your favor, call Mike Maggio today.*

## **MAGGIO LAW FIRM**

**your collection law firm**

2843 Prince Street, Conway, AR 72033 501-327-4340  
303 N. Spruce Street, Searcy, AR 72143 501-279-2769  
[www.ebaddebt.com](http://www.ebaddebt.com)

# Congressman Champions Patients' Rights

*Berry Awarded Shuffield Award for Legislative Efforts*

BY CHRISTY L. SMITH

Rep. Marion Berry, D-Ark., believes that doctors — not insurance companies — should make decisions regarding the treatment of patients.

To that end, the congressman from Arkansas' 1st district has been a tireless champion of a Patient's Bill of Rights to prevent insurance providers from interfering with treatment decisions and to hold them accountable if a patient is denied care. For his efforts in this cause, Berry recently received the highest honor the Arkansas Medical Society bestows upon a nonphysician each year — the Shuffield Award.

"In the face of enormous pressure from the insurance industry and their use of big business to fight their battles, our special honoree did the right thing," said Lynn Zeno, director of governmental affairs, at the AMS Annual Session in May.

But Berry said it took little to convince him something needs to be done to protect patients and physicians.

"It's not hard to get involved in something like health care . . . This whole issue of whether the doctor and the patient get to decide what's best for a patient or a clerk in an insurance company [get's to decide] is something I think strikes everyone's heart," he said.

Berry, who grew up near DeWitt, graduated from the University of Arkansas for Medical Sciences College of Pharmacy in 1965. He practiced pharmacy for three years before taking over the family farm in Gillett.

He entered public service in 1986, serving eight years on the Arkansas Soil and Water Conservation Commission, and was appointed special assistant to the president for Agriculture Trade and Food Assistance in 1993. He also served on the White House Domestic Policy Council.

In 1996, Berry was elected to the U.S. House of Representatives, where he is a member of many committees and serves as co-chairman of the House Prescription Drug Task Force, which is working to reduce the cost of prescription drugs for senior citizens, and the Democrat's Health Care Task Force.

The House passed a Patient's Bills of Rights last October. The measure ensures that patients receive the treatment they have been promised and have paid for, prevents insurance providers from interfering with doctors' decisions regarding treatment, ensures that patients can go to any emergency room without calling their health maintenance organization first, ensures that insurance



Marion Berry

providers grant access to specialists when needed and allows insurance plans to be sued for making adverse medical decisions.

A Senate version of that bill also passed last year, but it protects the insurance companies rather than the patients and physicians, Berry said. The issue of patient protection has now been assigned to a conference committee, a bipartisan group of representatives and senators who will try to work out the differences between the House and Senate version of the bills.

Berry said the fight to pass a patient protection bill is far from over. Pressure from constituents during the election year will ensure that the measure remains a top priority for legislators during the next congressional session, he said.

"The problem hasn't gone away; it's still out there. This should not be a partisan issue . . . It's an issue the American people have to deal with and for that reason we should go ahead and take care of it . . . But I can assure you that it will come up again in the 107th Congress," he said. ■





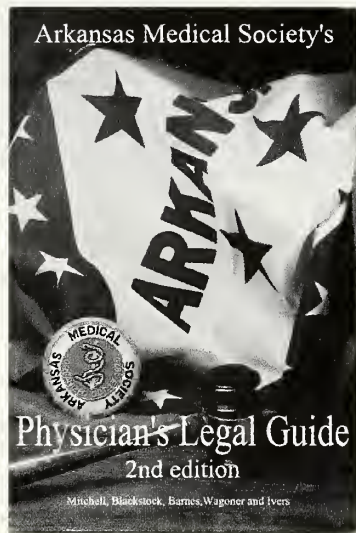
The Fifty Year Club honors those physicians who have held a license to practice medicine for 50 years and have loyally and effectively served the community — by skill and devotion to high ideals — upheld and maintained the standards of the medical profession. The Arkansas Medical Society hosted a breakfast for members of the Fifty Year Club May 6, at the Embassy Suites in Little Rock during the 124th AMS Annual Session.

Physicians who were inducted into the Fifty Year Club this year are: *Maurice K. Borklund, MD, Booneville; J.B. Cross,*

## The Fifty Year Club

*MD, Little Rock; Millard C. Edds, MD, Van Buren; Thomas A. Formby, MD,*

*Searcy; James H. French, MD, Hot Springs; G. Thomas Jansen, MD, Little Rock; James W. Marsh, MD, Warren; Stanley R. McEwen, MD, Fort Smith; Walter S. Mizell, MD, Little Rock; William R. Nixon, MD, Pine Bluff; William T. Paine, MD, Helena; Raymond E. Peeples, MD, Hot Springs; John E. Peters, MD, Little Rock; Fay M. Sloan, MD, Little Rock; Vestal B. Smith, MD, Marked Tree; Chaney W. Taylor, MD, Batesville; and Thomas E. Townsend, MD, Pine Bluff. ■*



### 2nd edition Arkansas Medical Society's Physician's Legal Guide

Be one of the first to obtain this guide which contains a multitude of state and federal laws affecting the practice of medicine. This guide is a valuable resource for physicians, clinic and hospital administrators, office staff, attorneys, regulators and many others.

**\$87<sup>00</sup>**  
List Price

**\$65<sup>00</sup>**  
for AMS  
members

**A 25%  
Discount!**

(Prices include shipping and handling.)

Check enclosed in the amount of: \$ \_\_\_\_\_

Please charge my Visa or Mastercard:

Cardholder's name: \_\_\_\_\_

Credit card No.: \_\_\_\_\_

Exp. date: \_\_\_\_\_

Cardholder's Signature: \_\_\_\_\_

☐ Please check if you are  
an AMS member.

Name: \_\_\_\_\_

Clinic: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_ Fax No.: ( ) \_\_\_\_\_

**CREDIT CARD ORDERS  
CAN BE FAXED TO:  
(501) 224-6489**

**Call the AMS office at 501-224-8967 or 800-542-1058 for volume discount pricing.**



# New Alliance President Touts Active Membership



Weber

Cynthia W. Weber, the new president of the Arkansas Medical Society Alliance, has big plans for her two-year term.

"My focus is to see how we can change the alliance to meet the needs of those who are eligible to become members," she said.

"I'm going to encourage our state membership chairs to work closely with counties to get buy-in from the members," Weber, 53, said, adding that her hope is the alliance will appeal to diverse members.

Groups in general, she said, have faced extreme difficulties keeping members interested in being active. The AMS Alliance, about 1,000 members strong in its heyday, now has about 500-600 members, a poor representation, Weber said.

Many factors are to blame for declining membership, including a younger gen-

eration of doctors whose marriages require that both partners work. "There's not a lot of time for volunteer organizations. Then, we compete with other volunteer organizations," she said.

"The other thing is to look at legislation, since this is a political year and the Legislature will be in session in January. We want to be proactive and help where we can," Weber said. "There are hundreds of bills that in one way or another directly or indirectly affect medicine."

Weber said her goal is to convince more members to devote time and effort to the Alliance.

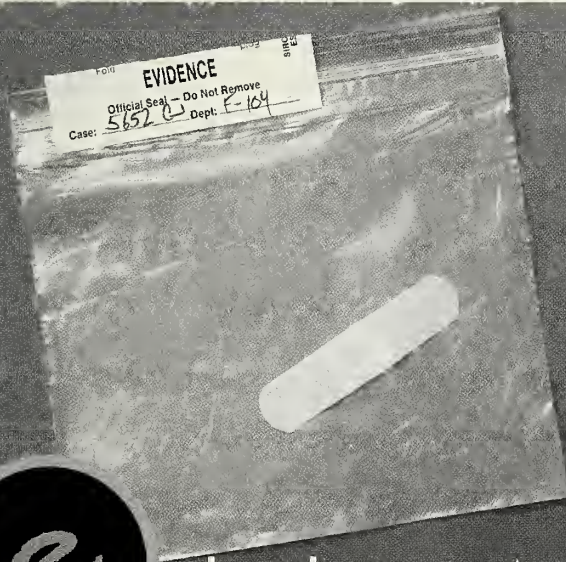
"I believe you can't become what you want to be by staying what you are," Weber said.

Weber, who is fluent in French and enjoys domestic and international travel, has 17 years experience in business management. She has been an Alliance member for about 20 years. Her husband, Jim, who died in 1998, was a family physician.

Weber is assistant director of education for the department of family and community medicine at the University of Arkansas for Medical Sciences. She has worked for the department since 1996, serving as an instructor, administrative director for clinical services and clinic program manager.

Previously, she was clinic administrator for her husband's practice, Weber Medical/Surgical Clinic in Jacksonville, for 11 years. Weber also worked at the West Oakland Health Center in Oakland, Calif., as assistant training coordinator and director of staff development, and as an education counselor. She was an assistant to the administrator of St. Vincent Infirmary in Little Rock, a school teacher at Roslyn High School in Long Island, N.Y., and a staff member on Gov. Winthrop Rockefeller's public relations office.

She is a member of the Rotary Club of Little Rock and a member of the Congregation B'Nai Israel board of directors. ■



## Exhibit A:

Adhesive bandage, which plaintiff alleges defendant pulled rapidly from skin, violently tearing three hairs from plaintiff's arm, which resulted in severe shock, trauma, disfigurement, chronic debilitating pain and permanent psychological damage.

Even the most absurd claims can be damaging if they're not handled properly. Which is why the full weight of our more than 60 years of experience in medical liability insurance is brought to bear on each and every claim, no matter how frivolous that claim may appear. In fact, when appropriate, we have appealed cases all the way to the United States Supreme Court, at no additional cost to policyholders. Because you can't put a bandage on a damaged reputation.

## The St Paul

©2000 St. Paul Fire and Marine Insurance Company  
Coverages underwritten by St. Paul Fire and Marine Insurance Company or another member of The St. Paul Companies

www.stpaul.com



*We're known for our abilities...*

# Flexibility.

We know you have a choice about your healthcare plan. That's why we offer the flexibility you want so you can get the care you deserve. We are Arkansas people working to take care of your health — we're Arkansas Managed Care Organization (AMCO).

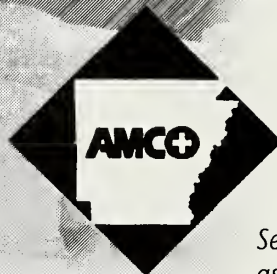
# Accountability.

Our statewide PPO network offers community care through:

- More than 3,800 physicians and hundreds of other healthcare professionals;
- Services in over 100 hospitals; and,
- An excellent staff representing your best interests.

# Stability.

AMCO is a recognized leader in managed healthcare in Arkansas, not only because of our size, but also for our high degree of accountability, outstanding customer service and stability.



Call us today at  
**1-800-278-8470** or  
**501-225-8470.**

#10 Corporate Hill Drive, Suite 200  
Little Rock, Arkansas 72205  
[www.amcoppo.com](http://www.amcoppo.com)

*Serving employers and their greatest asset with quality managed care.*

Putting the *Care* back in Managed HealthCare



# Report of the Council



*Members of the Arkansas Medical Society Council during the Annual Meeting May 5-6.*

## **Summary of Actions Taken:**

The Council met on Saturday, May 6, 2000, and the following business was received and transacted:

1. Approved the minutes of the Feb. 27, 2000, Council meeting and the March 22, 2000, Executive Committee meeting.
2. Received an update on the Arkansas Department of Human Services contract with Arkansas Behavioral Care to provide mental health services to Medicaid patients.
3. Discussed plans to meet with other health care organizations to research methods/programs for improving patient safety.
4. Approved \$25,000 of reserves be used as an initial step to support of the initiated act process for tobacco settlement negotiations and review for further participation as it progresses.
5. The Council approved requests for dues exemption from component societies.
6. The Council approved the following committee appointments:
  - **Budget Committee:** Brenda Powell, MD, Hot Springs
  - **Journal Editorial Board:** Reappoint Samuel Landrum, MD, Fort Smith, representing general surgery; Joseph Beck, MD, Little Rock, representing oncology; William Ackerman, MD, Little Rock, representing anesthesiology
  - **Medical Education Foundation for Arkansas:** Reappoint Martin Eisele, MD, Hot Springs, president
  - **Pension Plan Committee:** Reappoint John Wilson, MD, Little Rock

Reappoint Samuel Welch, MD, Little Rock

- **Arkansas Medical Foundation: Position No. 1:** Jerry Stringfellow, MD, Texarkana
  - **Young Physicians Task Force:** Kimberly Garner, MD, Pine Bluff, chairman
  - **Medical Student Councilor:** Mr. Erik Shultz, Little Rock
7. The Membership Report, Budget Report and MEFFA audit were presented for information.
  8. Voted to accept the Arkansas Medical Society audit.
  9. Discussed the Arkansas State Medical Board's proposed regulation relating to Alcohol and Mind Altering Substances in the Actively Treating Physician. The Arkansas State Medical Board is seeking Arkansas Medical Society assistance in establishing policy for a physician in active status of treating patients and the consumption of alcoholic beverages. Gave approval for an ad hoc committee to be formed to work on this issue.
  10. Discussed an issue with Medicaid and fetal non-stress test. The Council directed David Wroten, AMS assistant executive vice president, to continue discussions with the Arkansas Department of Human Services.
  11. Discussed a recent situation where a physician had been asked to sign a background verification disclosure and agree to allow a detective agency to investigate his background for a hospital staff application. The Council directed this issue be referred to the Executive Committee for review. ■



# Need to Brag?

Let your peers & colleagues know:  
Top-Flight Hospital Services,  
New Hires & Associates

**THE**  
**Journal**  
OF THE ARKANSAS MEDICAL SOCIETY

For Advertising Information,  
Contact Stephanie Hopkins  
501-372-2816 Ext. 293  
Email: [stephanie@abpg.com](mailto:stephanie@abpg.com)

# Report of the Arkansas Medical Society House of Delegates

---

## 1. Election of Officers:

**President-elect:** Joe Stallings, MD, Jonesboro

**Vice President:** Paul Wallick, MD, Monticello

**Treasurer:** Reappointed Dwight Williams, MD, Paragould

**Secretary:** Reappointed Carlton Chambers III, MD, Little Rock

**Speaker of the House:** Reappointed Anna Redman, MD, Pine Bluff

**Vice Speaker of the House:** Reappointed Kevin Beavers, MD, Russellville

### **Delegates to the AMA:**

Reappointed John Burge, MD, Lake Village

Reappointed William Jones, MD, Little Rock

### **Alternate Delegates to the AMA:**

Reappointed Lloyd Langston, MD, Pine Bluff

Hugh Jackson, MD, Fort Smith

### **District Councilors:**

**District 1:** Reappointed Roger Cagle, MD, Paragould

**District 2:** Jim Citty, MD, Searcy

**District 3:** Reappointed Parthasarathy Vasudevan, MD, Helena

**District 4:** Reappointed Harold Wilson, MD, Monticello

**District 6:** Reappointed Samuel Peebles, MD, Nashville

**District 7:** Reappointed Robert McCrary, MD, Hot Springs

**District 8:** Reappointed Thomas Eans, MD, Little Rock  
Reappointed Edward Saer, MD, Little Rock  
Reappointed John Wilson, MD, Little Rock

**District 9:** D. Wayne Brooks, MD, Springdale  
Thomas Langston, MD, Harrison

**District 10:** Reappointed Kenneth Seiter, DO, Fort Smith  
Reappointed William Galloway, MD, Russellville

**Medical Student Councilor:** Mr. Erik Shultz

2. Adopted the minutes of the 1999 House of Delegates meeting.

3. Dr. Joe Beck reported on Council action taken at the May 6, 2000, meeting. A summary will be printed in *The Journal of the Arkansas Medical Society*.

4. Dr. Carlton Chambers presented a report and plan of the Long-range Planning Committee. The plan is printed in this issue of *The Journal of the Arkansas Medical Society*. Voted to accept the plan as new business and accept it for information. Voted to authorize the Executive Committee and Council to move forward with the investigations, plans, committees and any other action that can be taken before the next House of Delegates meeting.

5. Announced the members of the 2000-2001 Nominating Committee. The members are:

**District 1:** Leonus Shedd, MD, Paragould

**District 2:** J. R. Baker, MD, Batesville

**District 3:** Marion McDaniel, MD, Helena

**District 4:** David Jacks, MD, Pine Bluff

**District 5:** Donya Watson, MD, El Dorado

**District 6:** Michael Young, MD, Prescott

**District 7:** Timothy Webb, MD, Hot Springs

**District 8:** C. Reid Henry, Jr., MD, Little Rock, secretary

**District 9:** Anthony Hui, MD, Fayetteville, chairman

**District 10:** Timothy Waack, MD, Fort Smith

6. Selected as nominees of the Arkansas State Board of Health and the Arkansas State Medical Board:

**1st Congressional District, Arkansas State Board of Health** — Dwight Williams, MD, Paragould; Leonus Shedd, MD, Paragould; G. Edward Bryant, MD, West Memphis;

**Member-at-Large, Arkansas State Board of Health** — Glenn Davis, MD, Little Rock; Kenneth Seiter, DO, Fort Smith; Linda McGhee, MD, Fayetteville;

**Arkansas State Medical Board** — C. Eldon Tommey, MD, El Dorado; Alan Wilson, MD, Crossett; Donald Blagdon, MD, Camden



# Long-range Planning Committee

*Co-chairmen Carlton Chambers, MD, and Scott Ferguson, MD*

In the summer of 1999, AMS President Dr. Lloyd Langston, appointed a steering committee to guide the AMS through a long-range planning process. The results of that process appear in the accompanying document. The purpose of this project was to examine the current trends and challenges facing Arkansas physicians and ensure that the AMS is well-positioned to continue the legacy of successful representation and advocacy on behalf of physicians and their patients.

The steering committee sought input from a broad representation of the AMS membership. An open letter went out asking grassroots physicians to volunteer their time and input for this project. To our surprise, more than 100 physicians agreed to participate. In order to make the best possible use of their time, two half-day meetings were held with identical agendas. This way, each physician could choose which day to attend. Not enough can be said about the efforts of these volunteers. They took time away from their practices and families to help make the AMS a better organization. They deserve our thanks and appreciation. Their names, along with the names of the steering committee members, appear in this report.

A facilitator was hired to organize the effort and keep us on track. At the two half-day meetings, participants were asked to identify key issues, strategies and make recommendations on specific actions. Following these meetings the steering committee met to review the information and begin developing specific goals and activities to achieve them.

The most profound finding to come from this process was

an obvious communication gap between the AMS and the membership. Many activities and programs were recommended that the AMS is already doing or has done in the past. For example, it was suggested that a web page be developed. The AMS has actually had a web site ([www.arkmed.org](http://www.arkmed.org)) for two years. It is not

so much that the AMS does not put the information out, it is that the information is not reaching the intended audience. To this end, the plan includes formation of an ad hoc committee to investigate and recommend improved communication strategies.

The plan contains recommendations for two additional committees to be formed. One of the goals is a 15% increase in membership by 2003. To accomplish this goal, member physicians will need to play a larger role in asking nonmembers to join. A committee is being recommended to accomplish this goal. Another major issue is governance, and includes issues such as how members are represented in the organizational structure, how officers are elected and the effectiveness and appropriateness of our policy making process. A committee has been recommended to review our current governance structure and recom-

mend any needed changes.

In conclusion, the accompanying long-range plan represents a beginning. Much work remains and ongoing efforts are needed to ensure that our AMS remains an effective, strong advocate for physicians and their patients. The plan represents the input and views from a wide spectrum of dedicated physicians all of whom have a common goal of wanting the Arkansas Medical Society to be the voice of Arkansas physicians. We must do whatever it takes to accomplish that goal. ■

## Committee Steering Group

Omar Atiq, Pine Bluff  
Joseph Beck, Little Rock  
Donald Blagdon, Camden  
Ms. April Davidson, Little Rock  
Denise Greenwood, Little Rock  
Anthony Hui, Fayetteville  
Hugh Jackson, Fort Smith  
William Jones, Little Rock

Lloyd Langston, Pine Bluff  
Thomas Langston, Harrison  
Charles Logan, Little Rock  
Michael Moody, Salem  
Brenda Powell, Hot Springs  
Joe Stallings, Jonesboro  
Gerald Stolz, Jr., Russellville  
Steven Thomason, Little Rock  
James R. Wharton, Springdale

## Volunteers

Russell Allison, Russellville  
L.J. Pat Bell, Helena  
Robert Bell, Russellville  
Raymond V. Biondo, North Little Rock  
Thomas Braswell, England  
Gilbert Buchanan, Little Rock  
John Burge, Lake Village  
Roger Cagle, Paragould  
Raines Chaffin, Bryant  
Rodney Chandler, Texarkana  
Robert Choate, North Little Rock  
Scott Claycomb, Warren  
George Covert, Ashdown  
Richard Dietzen, El Dorado  
Bradley Diner, Little Rock  
Thomas Eans, Little Rock  
Douglas Edmondson, El Dorado  
James Fasules, Little Rock  
Herbert Fendley, Pine Bluff  
Martin Fiser, Little Rock  
Kimberly Garner, Pine Bluff  
Sami Harik, Little Rock  
Marion Hazzard, Paragould  
Morriss Henry, Fayetteville  
David Jacks, Pine Bluff  
Carole Jackson, Conway  
Arthur Johnson, Fort Smith

Robert Jones, Benton  
Robert Kale, Fort Smith  
James Kolb, Jr., Russellville  
Mark Larey, Hot Springs  
Larry Lawson, Paragould  
Keith Lipsmeyer, Morrilton  
Don Lum, Pine Bluff  
John Lytle, Pine Bluff  
Peter MacKercher, Mountain Home  
Linda McGhee, Fayetteville  
David Millstein, Mountain Home  
Michael Moody, Salem  
David Murphy, Russellville  
Richard Nugent, Little Rock  
Nick Paslidis, Little Rock  
Curtis Patton, Forrest City  
Chester Peeples, West Memphis  
Leonus Shedd, Paragould  
Gregory Slagle, Hot Springs  
Scott Stern, Little Rock  
Steven Strode, Little Rock  
Parthasarathy Vasudevan, Helena  
Paul Wallick, Monticello  
Dwight Williams, Paragould  
John Williams, Huntsville  
Cynthia Willingham, Pine Bluff  
Alan Wilson, Crossett  
Morton Wilson, Fort Smith

# Arkansas Medical Society

## Long-range Plan

---

### **Mission**

To serve as the voice of Arkansas physicians.

### **Key Values**

- The highest standards of quality for health care.
- Preservation of the physician-patient relationship.
- Improved access to health care for all Arkansans.
- Integrity and ethical behavior.
- Excellence in service, programs and representation.
- Respect and trust.

### **Goals**

- Provide leadership in developing health care policy.
- Increase member involvement in AMS programs and activities.
- Improve the organizational strength of the AMS.
- Strengthen the role of AMS as an advocate for physicians and patients.
- Position the AMS as the leader in providing information, education and assistance to members.
- Produce a 15 percent increase in membership by 2003.

#### **A. Provide Leadership in Developing Health Care Policy**

##### **Strategies**

- Continue to strengthen AMS legislative and regulatory advocacy efforts.
- Use Internet technology to enhance communications with physicians regarding legislative and regulatory issues.
- Teach patients and physicians how to be proactive advocates for improving health care policies.

##### **Actions**

1. Sponsor meetings between the AMS leadership and the leadership of other physician and health care organizations to discuss current and emerging health care issues.
2. Seek ways to increase funding for AMS governmental affairs activities.
3. Sponsor a program for legislators to be "doctor for a day" through local physician offices.

4. Conduct regular meetings between AMS physician leadership and elected legislative leaders.
5. Sponsor periodic meetings between physicians and representatives of the various agencies/commissions to address physician and patient concerns.
6. Develop tools to inform physicians about the roles and responsibilities of the various agencies/commissions, with an emphasis on the role of AMS and physicians in the policy-making process.
7. Survey the leadership of medical specialty societies to help identify legislative issues that should be addressed by the AMS.
8. Utilize the AMS web site to improve communication with members during legislative sessions, including the formation of a bulletin board.
9. Provide information on the AMS web site for members to use in communicating with their patients about health care issues.
10. Provide material for physicians to use in their waiting rooms to educate patients about how to communicate with their state and federal legislators and agencies about health care issues.

#### **B. Increase Member Involvement in AMS Programs and Activities**

##### **Strategy**

- Recognize the changing nature of physicians' practices and physician demographics and develop programs and communication methods to meet their specific needs.

##### **Actions**

1. Conduct informal meetings and ongoing discussions with new physicians, women physicians, foreign-born physicians and employed physicians to identify programs, services and communication methods that better meet their needs.
2. Recruit representatives of the Society to make personal visits to physicians and physician groups to provide information and encourage involvement in the AMS.
3. Form an ad-hoc committee to investigate and recommend improved communication strategies, including a review of AMS publications and use of Internet-based technology.

*Continued*



### **C. Improve the Organizational Strength of the AMS**

#### **Strategies**

- Provide broader and more effective participation in the governance of the AMS with more informal avenues of participation.
- Establish an ongoing annual planning process.

#### **Actions**

1. Charge the AMS Executive Committee with the responsibility to annually review the long-range plan and recommend appropriate action to address emerging and evolving trends.
2. Establish a task force to review the strengths and weaknesses of the AMS organizational structure, and if needed, recommend changes to ensure broad representation, meaningful participation, continuity of leadership and the efficient conduct of business. This review should include, at a minimum, a critical look at each of the following:
  - a. House of Delegates
  - b. Council
  - c. Executive Committee
  - d. Nomination and election process
  - e. Representation of membership and membership groups

### **D. Strengthen the Role of AMS as an Advocate for Physicians and Patients**

#### **Strategies**

- Provide information and education to patients so they can become advocates for improved health care policies and preservation of the patient-physician relationship.
- Provide accurate and timely information on health care issues to the public.
- Recognize and promote contributions that physicians make to improve the quality of life and society.

#### **Actions**

1. Develop brochures, fact sheets and/or newsletters that physicians can utilize in their waiting rooms to help educate patients about health care issues.
2. Direct the ad hoc Committee on Communication to explore the development of a public relations plan to promote the AMS and its members' contributions to health care in Arkansas.
3. Develop public information/education programs in collaboration with other health-related groups such as the Arkansas Foundation for Medical Care and Arkansas Department of Health.
4. Submit regular articles and editorials to the media regarding current health care issues.
5. Establish an award to recognize physicians whose activities and lives epitomize the spirit and humanitarian nature of medicine. The award should be

modeled after the American Medical Association's Pride in the Profession program.

### **E. Position the AMS as the Leader in Providing Information, Education and Assistance to Members**

#### **Strategies**

- Improve member awareness of AMS activities and programs.
- Utilize new technologies to provide education and information.
- Develop new programs to meet the professional and business needs of members.

#### **Actions**

1. Formally request that the Board of Directors of the AMS' educational foundation, MEFFA, broaden its mission to include funding for AMS sponsored educational programs directed at practicing physicians, medical students and residents.
2. Develop a referral database for assistance and professional advice on issues such as coding, fraud and abuse, practice evaluation and contract review.
3. Develop a peer-to-peer assistance program to provide a referral source of physicians who are willing to share their experiences with computer systems, software, telephone systems and other topics.
4. Investigate the development of a Member's Only Section of the AMS web site to provide:
  - a. easy access to Internet-based and traditional continuing medical education resources;
  - b. bulletin board programs for discussion and exchange of ideas;
  - c. legislative updates and alerts;
  - d. online registration and payment for AMS sponsored programs and publications;
  - e. searchable database of AMS membership; and
  - f. information on AMS services and benefits

### **F. Produce a 15 % Increase in Membership by 2003**

#### **Strategies**

- Survey non-members to determine strategies for meeting their needs and recruiting them to the AMS.
- Target senior residents and medical students.
- Develop a grassroots physician-to-physician membership development plan.
- Increase involvement of new members in the Society.

#### **Action**

1. Establish a Committee on Membership to develop an effective physician-to-physician contact system for recruiting and retaining members and to assist the AMS staff in identifying effective strategies to strengthen the bond between physicians and the AMS. ■

*A Special Thank You to the following companies  
for their contributions to the 124th AMS Annual Session, May 5-6, 2000, at the  
Embassy Suites in Little Rock. This meeting would not have been possible without the  
financial support of these organizations.*

### **GOLD STAR CONTRIBUTORS**

AMS BENEFITS INC.  
AMERICAN INVESTORS LIFE INSURANCE CO.  
ARKANSAS BLUE CROSS AND BLUE SHIELD  
ARKANSAS FOUNDATION FOR MEDICAL CARE  
ARKANSAS MANAGED CARE ORGANIZATION (AMCO)  
AVENTIS PHARMACEUTICALS  
BANK OF MULBERRY  
BANK OF THE OZARKS TRUST SERVICES  
BAYER PHARMACEUTICALS  
MEDICAL ASSURANCE  
METROPOLITAN NATIONAL BANK  
REGIONS BANK  
STATE VOLUNTEER MUTUAL INSURANCE CO.

### **2000 AMS EXHIBITORS**

AMS BENEFITS INC.  
ARKANSAS ARMY NATIONAL GUARD MEDICAL RECRUITING TEAM  
ARKANSAS BLUE CROSS AND BLUE SHIELD  
ARKANSAS HEALTH CARE ACCESS FOUNDATION  
ARKANSAS HEART HOSPITAL  
ARKANSAS MANAGED CARE ORGANIZATION (AMCO)  
ARKANSAS MEDICAID DEFERRED COMPENSATION PROGRAM  
ARKANSAS MEDICAL GROUP MANAGEMENT ASSOCIATION  
ARKANSAS MEDICAL SOCIETY  
BECKER INC. — PRODENCO  
COMMODORE MEDICAL SERVICES  
DIAGNOSTIC IMAGING  
DISABILITY DETERMINATION FOR SOCIAL SECURITY  
DIVERSIFIED INVESTMENT ADVISORS  
DOCTORS INSURANCE RECIPROCAL

EMPLOYERS HEALTHCARE RESOURCES  
G.D. SEARLE  
HORTON'S ORTHOTIC LAB INC.  
HUTCHINSON/IFRAH FINANCIAL SERVICES INC.  
JEFFERSON REGIONAL MEDICAL CENTER  
KEY PHARMACEUTICALS  
KOS PHARMACEUTICALS  
LEE PHARMACY  
MARTEK USA INC.  
MEDICAID MANAGED CARE SERVICES  
METROPOLITAN NATIONAL BANK  
PATHOLOGY PRACTICE MANAGEMENT & TRI-PATH CORP.  
PERSONAL COMMUNICATION SYSTEMS (PCS)  
PFIZER — LABS, PRATT AND STEERE DIVISIONS  
PROFESSIONALS ADVOCATE (PROAD) INSURANCE CO.  
REHABCARE GROUP  
RESEARCH SOLUTIONS  
ROCHE LABORATORIES  
SCHERING CORP.  
SCHERING ONCOLOGY/BIOTECH  
SMITHKLINE BEECHAM PHARMACEUTICALS  
SNELL PROSTHETIC & ORTHOTIC LABORATORY  
SPRINT PCS  
ST. PAUL COMPANIES  
STATE VOLUNTEER MUTUAL INSURANCE CO.  
TAP PHARMACEUTICALS  
U.S. AIR FORCE  
U.S. ARMY HEALTH CARE RECRUITING  
WEB MD  
WORLD WIDE TRAVEL



# PEOPLE+EVENTS

## Radiology Association Honors Dr. Ferguson for Distinguished Public Service

Dr. Scott Ferguson, a West Memphis radiologist, recently received the Distinguished Service Award by the American Chapter of the College of Radiology.

Dr. Ferguson, a former state representative, was honored with the award in recognition for outstanding public service in health care. A radiologist at Outpatient Radiology in West Memphis and Baptist Memorial Hospital in Osceola, he served on the state legislature's Public Health, Labor and Welfare Committee and the City and County Affairs Committee.

"I was really very honored and very pleased," Dr. Ferguson said about receiving the award.

He worked in the legislature and the Arkansas Medical Society to advance patients' rights legislation and traveled to Washington, D.C., to lobby senators and congressmen for passage of the Patients' Bill of Rights.



Dr. Scott Ferguson, left, receives the Distinguished Service Award from the Arkansas chapter of the American College of Radiology from Dr. Terry Olson, president of the radiology group.

## HONORED

### Dr. Eans Attains MRO Certification, Publishes Article

Dr. Thomas Eans of Southwest Family Clinic in Little Rock recently became certified as a medical review officer.

Dr. Eans, a general practice physician, earned the credentials from the American Association of Medical Review Officers Inc., a non-profit medical society created in 1991 to establish national standards and certification of medical practitioners and other professionals in the field of drug and alcohol test-

ing. Certification is intended to ensure quality services and ethical conduct by professionals involved in drug and alcohol testing.

The MRO is an integral part of federally mandated drug testing programs and balances the protected rights of the tested individual and the concerns for health and safety in the workplace.

Dr. Eans also recently published an article, "New HCFA Drug-Prescribing Criteria for Nursing Homes and Suggested Alternate Prescribing to Avoid Care Deficiencies" in the February 2000 issue of the *Annals of Long-Term Care: Clinical Care and Aging*.

### AMA Names PRA Recipients

Each month the American Medical Association presents the Physician's Recognition Award to those who have completed acceptable programs of continuing education.

AMA recipients for March include Drs. Sorin Jos Brull, Hugh F. Burnette and Carlton L. Chambers, all of Little Rock, and Dr. Wilbur M. Giles of Newport.

### Ceremony Marks Dedication of Schoettle Center

The Dr. Glenn P. Schoettle Medical Education Center at Crittenden Me-

morial Hospital was dedicated this year with Dr. Schoettle's family on hand for the ceremony that marked the opening of the new building.

The 7,500-square-foot building features a 76-seat auditorium, two meeting rooms and a physicians' study room. The center is equipped with state-of-the-art technology facilities for meetings and seminars, including satellite uplinks for medical conferencing.

The Glenn Schoettle family donated the center to honor the former herald and teacher of health care professionals.

## OBITUARIES

### Paul J. Cornell, MD

Dr. Paul J. Cornell, 64, of Little Rock and Boundurant, Wyo., a retired practitioner of obstetrics and gynecology, died May 17, 2000.

Dr. Cornell attended Tulane University and Louisiana State University Medical School and completed his internship in obstetrics and gynecology in the U.S. Army Medical Corps. He served as commanding officer of two Army surgery evacuation hospitals in the TET Offensive in the Vietnam War.

Dr. Cornell was active in the Arkansas Medical Society as a councilor and served as the Pulaski County Medical Society president in 1979. He is survived by his wife, JoAnn Louise Cornell; his mother, Anne A. Cornell of Little Rock; a brother; three children; and eight grandchildren.

### Donald J. McMinimy, MD

Dr. Donald J. McMinimy, 80, FACP, of Fort Smith died May 15, 2000. He was an internal medicine physician with Holt-Krock Clinic for 30 years and a Navy veteran. He also was a member of First Baptist Church, the Sebastian County Medical Society, American Medical Association and the American College of Chest Physicians. He was a fellow in the American College of Physicians.

He is survived by his wife of 58 years, Nell, a daughter, three grandchildren and one great-granddaughter.

### Frank M. Burton, MD

Dr. Frank M. Burton, 92, a general surgeon in Hot Springs, died May 5, 2000, in St. Joseph's Regional Health Center from heart and kidney failure.

Dr. Burton practiced medicine for 40-plus years with Dr. W. Martin Eisele at the Burton-Eisele Clinic on Whittington Avenue, established in 1955. Over his career, Dr. Burton served as chief of staff at St. Joseph's Hospital and secretary of the Levi Memorial Hospital Physicians' Staff. A fellow in the American College of Surgeons, he also was a member of the Southwest Surgical Congress, the International College of Surgeons and the

(Continued)

There are plenty of full service banks.  
So where are all the full service bankers?

If you want the type of personal service that's missing from most full service banks these days, call Metropolitan National Bank's Professional Banking Group. Our highly specialized team, led by Senior Vice President George Penick (978-7632), focuses exclusively on helping those with substantial assets, but limited time to maximize their potential.

Just make the SimpleSwitch to our Professional Banking Group at Metropolitan. We'll give you the personal service you've been looking for.



Little Rock, North Little Rock, Sherwood,  
Benton, Bryant and Conway

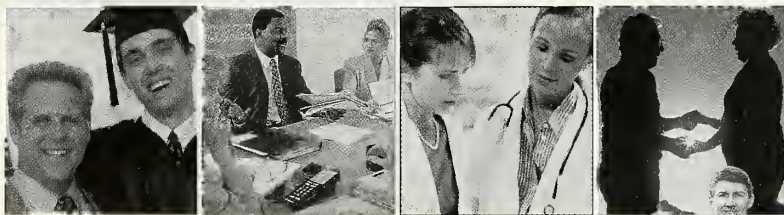
N E A R B Y & N E I G H B O R L Y.

www.metbank.com

Member FDIC



## For the Investments of your Life...



**I**NVESTING is not "The End." Investing is "The Means." The desired end is reached by planning, growing and finishing well. Our expertise is implementing investment strategies that best empower *your* plans for growing and finishing well.

Clients include individuals, retirement plans, trusts and foundations. All enjoy a competitive fee-only service. We can add value and peace of mind to the investments of your life.

(Left to Right). Bill Smith, Keith McCullough,  
Jim Strawn and Stephen Chaffin.



THE BEST CHOICE IS AN INDEPENDENT INVESTMENT ADVISOR



**SMITH  
CAPITAL  
MANAGEMENT**

Pleasant Valley Office Center  
12115 Hinson Road  
Little Rock, AR 72212  
501/228-0040 or 800/866-2615  
fax 501/228-0047



American Medical Association.

A 1934 graduate of the University of Arkansas School of Medicine in Little Rock, he spent his internship in Shreveport, La., at Charity Hospital.

Dr. Burton also was a long-time president and secretary of the Arkansas State Medical Board, and he was a U.S. Army Reserves and U.S. Army Medical Corps veteran, serving as chief of staff of the U.S. Army at Omaha Beach.

Dr. Burton, president of the Caduceus Club of the Arkansas Medical Society, was active in educational, civic, medical military and church aspects of his community, and he was a descendant of the Belding family, the original permanent settlers who arrived in Hot Springs from Amherst, Mass., in 1828.

Dr. Burton was married to his wife, LaRue Roman Williams Burton, for 59 years. He is survived by a son, daughter, grandson, a sister and many nieces and nephews.

### **Clark M. Baker, MD**

**Dr. Clark M. Baker** of Paragould died May 29 at his home. Dr. Baker had practiced medicine in Paragould 41 years, retiring in 1989. Born in Maynard, he received his bachelor's degree from Arkansas State University and was later Bono School District superintendent until attending medical school in 1942, graduating in 1945. He interned at St. Vincent Infirmary in Little Rock, then attended the School of Aviation Medicine at Randolph Field, Texas, until 1947. Dr. Clark served with the U.S. Army at the 49th General Hospital in Tokyo in 1948, and he was base surgeon at the 3rd Group, Yokota Air Force Base. Dr. Clark was a member of the original medical staff of Community Methodist Hospital (now Arkansas Methodist Hospital) in 1949. He served as chief of staff at AMH in Paragould in 1955, 1960 and 1970. He also was a member of the Greene-Clay County Medical Society, the Arkansas Medical Society and the American Medical Association, and he also was an avid ham radio operator with the call numbers WA5KQS. ■

## **ARKANSAS MEDICAL SOCIETY OFFICERS 2000-2001**

### **Executive Committee**

**Chairman of the Council:** Joseph Beck, Little Rock  
**President:** Gerald Stolz, Russellville  
**President-elect:** Joe Stallings, Jonesboro  
**Secretary:** Carlton Chambers, Little Rock  
**Treasurer:** Dwight Williams, Paragould  
**Immediate Past President:** Lloyd Langston, Pine Bluff

### **Other Officers**

**Vice President:** Paul Wallick, Monticello  
**Speaker of the House:** Anna Redman, Pine Bluff  
**Vice Speaker:** Kevin Beavers, Russellville

### **Medical Student Section Officers**

**President:** Dwight Johnson, Little Rock

**Vice President:** Charles Mashek, Little Rock

**Secretary/Treasurer:** Matthew Kincade, Maumelle

**AMS Delegate:** Blake Geren, Little Rock

**AMS Alternate Delegate:** Heather Diemer, Little Rock

### **AMA Delegates**

John Burge, Lake Village  
William Jones, Little Rock  
Larry Lawson, Paragould

### **AMA Alternate Delegates**

Lloyd Langston, Pine Bluff  
Charles Logan, Little Rock  
Hugh Jackson, Fort Smith  
Michael Moody, Salem

## **COUNCILORS 2000-2001**

### **Medical Student Councilor**

Erik Shultz, Little Rock

### **District 1:**

Roger Cagle, Paragould  
Scott Ferguson, West Memphis  
**Counties:** Clay, Craighead, Crittenden, Greene, Lawrence, Poinsett, Randolph

### **District 2:**

Lloyd Bess, Batesville  
Jim Citty, Searcy  
**Counties:** Cleburne, Conway, Faulkner, Fulton, Independence, Izard, Jackson, Sharp, Stone, White

### **District 3:**

Dennis Yelvington, Stuttgart  
P. Vasudevan, Helena  
**Counties:** Arkansas, Cross, Lee, Lonoke, Monroe, Phillips, Prairie, St. Francis, Woodruff

### **District 4:**

John O. Lytle, Pine Bluff  
Harold Wilson, Monticello  
**Counties:** Ashley, Chicot, Desha, Drew, Jefferson, Lincoln

### **District 5:**

William Dedman, Camden  
**Counties:** Bradley, Calhoun, Cleveland, Columbia, Dallas, Ouachita, Union

### **District 6:**

Michael Young, Prescott  
Samuel Peebles, Nashville

**Counties:** Hempstead, Howard, Lafayette, Little River, Miller, Nevada, Pike, Polk, Sevier

### **District 7:**

Brenda Powell, Hot Springs  
Robert McCrary, Hot Springs  
**Counties:** Clark, Garland, Grant, Hot Spring, Montgomery, Saline

### **District 8:**

Joseph Beck, Little Rock  
Thomas Eans, Little Rock  
C. Reid Henry, Little Rock  
William Jones, Little Rock  
John L. Wilson, Little Rock  
J. Mayne Parker, Little Rock  
Anthony Johnson, Little Rock  
Samuel Welch, Little Rock  
**County:** Pulaski

### **District 9:**

Anthony Hui, Fayetteville  
Thomas Langston, Harrison  
Jan Turley, Rogers  
D. Wayne Brooks, Springdale  
**Counties:** Baxter, Benton, Boone, Carroll, Madison, Marion, Newton, Searcy, Van Buren, Washington

### **District 10:**

Robert Sanders, Fort Smith  
William Galloway, Russellville  
Mike Berumen, Fort Smith  
Kenneth Seiter, Fort Smith  
**Counties:** Crawford, Franklin, Johnson, Logan, Perry, Pope, Scott, Sebastian, Yell ■

Some dealer's waiting list is two years...

Ours is more  
like two  
days.



HONDA S2000

MERCEDES-BENZ S430



At Autoflex Leasing,  
hard to find cars are  
our specialty.

Whether it's a Mercedes S500 or S430, the CLK Cabriolet or all new Honda S2000, your "hard to find" car could be just a phone call away. After all, your patients don't like waiting...Why should you?



**Autoflex**  
L E A S I N G

**1-888-234-1234**





## ADVERTISERS INDEX

Air Force .....	48
AMS Benefits Inc. ....	Inside back cover
Arkansas Financial Group Inc., The .....	42
Arkansas Foundation for Medical Care .....	Inside Front Cover
Arkansas Managed Care Organization .....	58
Autoflex Leasing .....	69
Easter Seals .....	44
Employers Healthcare Resources Inc. ....	48
Guest House Inn .....	43
HealthLink of Arkansas .....	48
Hoffman-Henry Insurance Corp. ....	49
Hutchinson/Ilfrah Financial Services Inc. ....	44
Little Rock Medical Association .....	50
Maggio Law Firm .....	54
Medicus .....	49
Metropolitan National Bank .....	67
PhyAmerica Physician Services Inc. ....	53
Regions Bank .....	50
Riverside Motors .....	39
St. Paul Medical Services .....	57
Smith Capital Management .....	67
Snell Prosthetic & Orthotic Laboratory .....	Back Cover
Southwest Capital Management Inc. ....	49
State Volunteer Mutual Insurance Co. ....	40
University of Arkansas for Medical Sciences .....	70

Special Publications Publisher  
*Brigette Williams*

Editorial Art Director  
*Irene Forbes*

Special Publications  
Editor-in-Chief  
*Natalie Gardner*

Advertising Art Director  
*Matt Stewart*

Managing Editor  
*Judith M. Gallman*

Advertising Coordinator  
*Kristen Ebbing*

Assistant Editor  
*Christy L. Smith*

Marketing Assistant  
*Mitzi Tiffie*

Sales Manager  
*Stephanie Hopkins*

Database Administrator  
*H.L. Moody*

Account Executive  
*Liz Earlywine*

Advertising Assistant  
*Steven White*

Director of Design  
& Circulation  
*Virgeen Healey*

 **ARKANSAS BUSINESS  
PUBLISHING GROUP**

Production &  
Circulation Coordinator  
*Jeremy Henderson*

Chairman and  
Chief Executive Officer  
*Olivia Farrell*

President and Publisher  
*Jeff Hankins*

© 2000 Arkansas Business Publishing Group  
[www.abpg.com](http://www.abpg.com)

Executive Vice President  
*Sheila Palmer*

# Colorectal Cancer Symposium: Learn New Treatments, Earn CME.

On September 23, physicians from across Arkansas will come together to learn the latest medical breakthroughs in colorectal cancer at the 4th Annual Charles William Rasco III Symposium on Colorectal Cancer. Topics include:

- New treatment modality for liver metastases
- The role of colon cancer screening in cancer prevention
- PET scanning in colon cancer
- Prevention of colon cancer with COX II inhibitors
- Microsatellite instability as a predictor of colon cancer risk
- Colorectal cancer screening: fecal blood vs DNA
- Endoscopic ultrasonography
- Thalidomide in combination with chemotherapy for colon cancer

WHEN: Saturday, September 23 - 8 a.m. to 4 p.m.

WHERE: Sam Walton Auditorium, Arkansas Cancer Research Center on the campus of UAMS in Little Rock.

FEE: The \$100 registration fee includes refreshments, lunch and educational materials. CME hours are also awarded to attendees.

For more information call Courtney Terry at (501) 686-7912.



UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES



# Arkansas Medical Society Health Benefit Plan...



AMS BENEFITS, INC.

A wholly owned subsidiary of the  
Arkansas Medical Society

P. O. Box 55088

Little Rock, Arkansas 72215-5088

(501) 224-8967

WATS 1-800-542-1058

FAX (501) 224-6489

Ask about our other services including  
Professional Overhead, Disability  
& Life Insurance.



*tailor-made for physicians*

The Arkansas Medical Society Health Benefit Program is a health insurance plan designed exclusively for members of the Arkansas Medical Society. Underwritten by American Investors Life Insurance Company. Indemnity and managed care plans available. For information call (501) 224-8967 or 1-800-542-1058.



Now Open in Jonesboro.

*Pledging commitment is one of the most important things that human beings can do for one another. It means I'll do only my best for you. I'll fight for your rights. I'll be there for you.*

*At Snell Laboratory we make that type of commitment to each of our patients. We dedicate ourselves to making them as comfortable and as mobile as possible. We give them back as much of their former life as we can.*

# A MATCH MADE IN HEAVEN.



Health Sciences Library  
University of Maryland  
Acquisitions/Serials Dept.  
601 W LOMBARD ST  
BALTIMORE MD 21201-1512

*Our computer-aided design and manufacture (CAD/CAM) system makes so much more possible in creating custom-fit prostheses than ever before. And new lightweight, space age materials mean more for our patients with custom orthoses. So regardless of what responsibilities your*

*patients agree to in life, from going out to play to attending a special occasion, our commitment to comfort never waivers.*

*Snell Prosthetic and Orthotic Laboratory has been in business since 1911. We've said "I do" to our patients since day one.*



**SNELL**  
Prosthetic & Orthotic  
Laboratory

THE LATEST IN TECHNOLOGY. THE BEST IN CARE.

Offices located in Little Rock, Russellville, Fort Smith, Mountain Home, Fayetteville, Hot Springs, North Little Rock, and Jonesboro.

**Little Rock (501) 664-2624 • Statewide Toll-free 1-800-342-5541**

Founding Members of PrimeCare O&P Network - serving the southern United States.



# THE Journal

OF THE ARKANSAS MEDICAL SOCIETY

Vol. 97 No. 3

September 2000

## Women in Medicine

Arkansas Physicians  
Examples of Progress

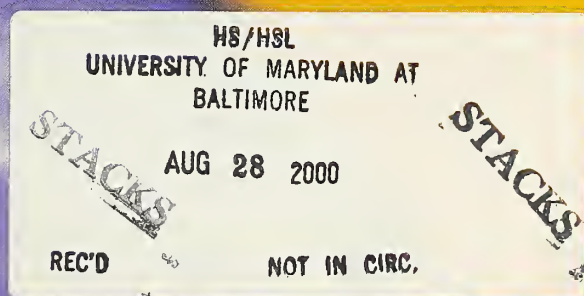
Fighting for  
Patients' Rights

President Al Gore  
Little Rock


Brilliant Disguise

We Can't Always  
Be the Perfect Doctor

\*\*\*\*\*MIXED ADC 050 S3 P2  
Health Sciences Library  
University of Maryland  
Acquisitions/Serials Dept.  
601 West Lombard St.  
Baltimore MD 21201

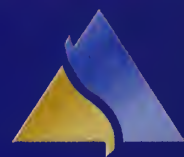






There's an easier way  
to protect yourself  
from pneumonia.

**THE PNEUMONIA VACCINE.** It's a safe, one-time shot that protects you for life. For more information, talk to your doctor or call **1-877-650-AFMC.**



*Arkansas Foundation  
for Medical Care*



Now you can afford to have a mid-30's crisis.



It's the best preemptive strike on middle-age yet. With a 185 hp Kompressor engine, the C230 also comes standard with features like the Electronic Stability Program, regular scheduled maintenance\* and 24-hour Tele Aid\*\* assistance, making for one sweet ride at an incredibly attractive price. You'll feel younger and a heck of a lot wiser too. **The C-Class, starting at \$31,750.<sup>†</sup>**



Mercedes-Benz

Riverside Motors, Inc.

1403 Rebsamen Park Road, Little Rock, AR (501) 666-9457

†MSRP for a C230 Kompressor at \$31,750 excludes \$645 transportation charge, all taxes, title/documentary fees, registration, tags, retailer prep charges, insurance, optional equipment, certificate of compliance or noncompliance fees, and finance charges. Prices may vary by retailer. \*As called for by the Flexible Service System. Wear items excluded. Limitations apply. See your Mercedes center for a copy of the Mercedes-Benz limited warranty and details of The Mercedes Maintenance Commitment. \*\*Tele Aid requires consumer subscription for monitoring service, connection charge, and air time. Available only in cellular service areas. First year's monitoring, subscription, monthly access fees, and 30 minutes of air time included at no cost. See retailer for details. For more information, call 1-800-FOR-MERCEDES, or visit our Web site, [www.MBUSA.com](http://www.MBUSA.com). AIR BAGS ARE A SUPPLEMENTAL RESTRAINT SYSTEM, SO REMEMBER AIR BAG SAFETY: BUCKLE EVERYONE AND CHILDREN IN BACK! © 2000 Authorized Mercedes-Benz Retailers



Now Open in Jonesboro.

*Pledging commitment is one of the most important things that human beings can do for one another. It means I'll do only my best for you. I'll fight for your rights. I'll be there for you.*

*At Snell Laboratory we make that type of commitment to each of our patients. We dedicate ourselves to making them as comfortable and as mobile as possible. We give them back as much of their former life as we can.*

# A MATCH MADE IN HEAVEN.



*Our computer-aided design and manufacture (CAD/CAM) system makes so much more possible in creating custom-fit prostheses than ever before. And new lightweight, space age materials mean more for our patients with custom orthoses. So regardless of what responsibilities your*

*patients agree to in life, from going out to play to attending a special occasion, our commitment to comfort never waivers.*

*Snell Prosthetic and Orthotic Laboratory has been in business since 1911. We've said "I do" to our patients since day one.*



**SNELL**  
Prosthetic & Orthotic  
Laboratory

THE LATEST IN TECHNOLOGY. THE BEST IN CARE.

Offices located in Little Rock, Russellville, Fort Smith, Mountain Home, Fayetteville, Hot Springs, North Little Rock, and Jonesboro.

Little Rock (501) 664-2624 • Statewide Toll-free 1-800-342-5541

Founding Members of PrimeCare O&P Network - serving the southern United States.

## CONTENTS

### FEATURES

- 82 **Vice President Pushes for Patients' Bill of Rights**  
*Vice President Al Gore recently paid a visit to Little Rock touting passage of the Patients' Bill of Rights. Little Rock breast surgeon Dr. Denise Greenwood told of her own horrors with insurance companies and introduced Gore.*
- 83 **It's Not a Man's World Anymore**  
*September is Women in Medicine month, and The Journal profiles six of the state's outstanding women physicians. Although women doctors faced hurdles in the beginning, they are now major contributors to medicine. Almost 40% of current medical students are women.*
- 84 Dr. Susan Ward-Jones, rural health
- 86 Dr. Sandra Marchese Johnson, dermatology research
- 88 Dr. Sidney Hayes, state Medicare medical director
- 90 Dr. Sue Chamber, pediatrics
- 92 Dr. Brenda Powell, obstetrics/gynecology
- 94 Dr. Anna Redman, family practice



Physicians must maintain a human touch despite patient's expectations of perfection.

— page 79



Vice President Al Gore spoke about the Patients' Bill of Rights during a recent campaign stop.

— page 82

### DEPARTMENTS

- |                                              |                                 |
|----------------------------------------------|---------------------------------|
| 79 <b>Commentary</b><br><i>Lee Abel, MD</i>  | 98 <b>Cardiology Report</b>     |
| 81 <b>What We've Done<br/>For You Lately</b> | 101 <b>People + Events</b>      |
| 96 <b>Loss Prevention</b>                    | 102 <b>Index to Advertisers</b> |



# MEDICAID HORIZONS

*A panorama of innovations built on past successes*

SEPTEMBER 21, 2000

DOUBLETREE HOTEL, LITTLE ROCK



Register now for this intensive one-day conference  
focused on the national award-winning Arkansas  
Medicaid program and its future.

## Medicaid Horizons

### National Trends and Issues

### Long-Term Care

### Partnerships

### Outreach to Uninsured Children

### Technological Advances

### External Quality Review

The program will feature key state and  
national leaders, including:

*Service Oversight*  
**Timothy Westmoreland**, Director,  
Center for Medicaid and State  
Operations, HCFA

*Social Change*  
The Honorable **Mike Huckabee**,  
Governor of Arkansas

**Space is limited. Register today!**

For more information, call toll-free

1-888-687-1200 or visit

[www.civil.org](http://www.civil.org) & click on the

Medicaid Horizons banner



### COMMUNICATIONS COORDINATOR

Judy Hicks

### EXECUTIVE VICE PRESIDENT

Kenneth LaMastus, CAE

### ASSISTANT EXECUTIVE VICE PRESIDENT

David Wroten

### EDITORIAL BOARD

Jerry Byrum, MD	Pediatrics
Joseph M. Beck, II, MD	Oncology
Lee Abel, MD	Internal Medicine
Samuel Landrum, MD	Surgery
Jerry Kendall, MD	Family Practice
William Ackerman, MD	Anesthesiology

### EDITOR EMERITUS

Alfred Kahn Jr., MD

### ARKANSAS MEDICAL SOCIETY

#### 2000-2001 OFFICERS

Gerald A. Stolz, Jr., MD, Russellville  
*President*

Joe Stallings, MD, Jonesboro  
*President-elect*

Paul A. Wallick, MD, Monticello  
*Vice President*

Lloyd G. Langston, MD, Pine Bluff  
*Immediate Past President*

Carlton L. Chambers, III, MD, Harrison/Little Rock  
*Secretary*

Dwight M. Williams, MD, Paragould  
*Treasurer*

Anna Redman, MD, Pine Bluff  
*Speaker, House of Delegates*

Kevin Beavers, MD, Russellville  
*Vice Speaker, House of Delegates*

Joseph M. Beck, II, MD, Little Rock  
*Chairman of the Council*

Established 1890. Owned and edited by the Arkansas Medical Society and published under the direction of the Council.

**Advertising Information:** Contact Stephanie Hopkins, P.O. Box 3686, Little Rock, AR 72203; (501) 372-2816.

**Postmaster:** Send address changes to: *The Journal of the Arkansas Medical Society*, P. O. Box 55088, Little Rock, Arkansas 72215-5088.

**Subscription rate:** \$30.00 annually for domestic; \$40.00, foreign. Single issue \$3.00.

*The Journal of the Arkansas Medical Society* (ISSN 0004-1858) is published monthly by the Arkansas Medical Society, #10 Corporate Hill Drive, Suite 300, Little Rock, Arkansas 72205. Printed by The Ovid Bell Press, Inc., Fulton, Missouri 65251. Periodicals postage is paid at Little Rock, Arkansas, and at additional mailing offices.

Articles and advertisements published in *The Journal* are for the interest of its readers and do not represent the official position or endorsement of *The Journal* or the Arkansas Medical Society. *The Journal* reserves the right to make the final decision on all content and advertisements.

Copyright 2000 by the Arkansas Medical Society.

# Brilliant Disguise

BY LEE ABEL, MD

**B**ruce Springsteen was coming to town. In recognition of this, we put on the Springsteen greatest hits CD for our dinner cleanup music. It's a sign of my age I guess, but I think the chief function of rock 'n' roll music is to make dinner cleanup more enjoyable. I can do some really cool moves as I sponge off the kitchen table, although this seems to make my two teen-agers gag. I often don't pay much attention to the lyrics, but on this particular night I did and was intrigued by Springsteen's song "Brilliant Disguise." It's a great tune; maybe you know the refrain: So tell me who I see/ When I look in your eyes/ Is that you baby/ Or just a brilliant disguise?

As physicians we have opportunities to see that the external, the superficial appearance — the sometimes brilliant disguise — is just one aspect of a person and not the whole picture. The song made me think of a patient who seems to be the very epitome of success but in the exam room another side emerged. He was worried and unhappy and generally dissatisfied with his life, despite the external appearance of happiness, affluence and success. I also thought of a woman I have seen whose external appearance was immaculate (maybe even perfect) but in the exam room the surface image gave way to an inner picture of anxiety, turmoil and despair.

This is not unusual. We are social animals, and most of us want acceptance and approval. We think about the image we present to others and want other people to think we "have it all together." Advertisers use this need constantly. We are exhorted to buy products because as one ad used to say, "It says so much about you."

We also receive pressure from other people to be a certain way because of their needs. I once saw a patient who was a pastor in a small town who came to see me because he was fatigued. He was a very good person, but he felt his congregation wanted him to be perfect. He tried to be always kind, patient, loving and unselfish, but he couldn't quite manage it. The pressure to be perfect became burdensome, and I think this was the cause of his exhaustion.

Doctors also have a lot of pressure to meet certain expectations. Patients want to see us as wise and compassionate — indeed they may hope we are "called to" medicine as people are "called to" the ministry. Patients may invite us to wear the mask that fulfills their fantasy of the perfect doctor, and sometimes their invitation can be quite persuasive. There is a part of us that would like to be the perfect doctor, a part that would like to meet our patients' expectations even if those expectations are unrealistic. And maybe we feel guilty when we don't.

In medical school we learned to play the role of a doctor before we were doctors. We were taught what image to project. The lessons were implicit and explicit. On my third year surgery rotation the attending wanted us to answer all his questions with confidence and an air of certainty. He told us he would rather us give the wrong answer in a confident demeanor than to give the

correct answer in a timid and unsure manner. I found this difficult, and I found the attending intimidating, but I think I now have some insight into what he was doing. I think he believed that we would all eventually get the right answers and score well on written tests; what he felt we needed to learn and couldn't learn from books was an attitude of confidence and authority. I think he believed that this attitude was essential to the healing work of a physician. Being able to convince the patient they are going to get better is a very valuable skill.

Of course, the authoritarian and paternalistic mask that my surgical attending encouraged has its limitations. In that role it could be hard for a doctor to say, "I don't know," and shameful to say, "I'm not sure." Doctors could be very certain and very wrong. "Your father has two months to live." "This patient will never walk again." This model could sometimes give rise to a harsh judgmental attitude. In addition, patients were often treated as passive bystanders rather than active participants in their care. They were given reassurance but little information.

This style of practice is not as common now as it was in the past. Nowadays there is a tendency to go to the other extreme. The legal system is so threatening and punitive that it can activate our self preservation instincts. It encourages a defensive way of relating to patients that can make giving reassurance feel legally risky. It can feel safer to wear a legalistic mask and emphasize the uncertainties or just keep ordering more tests. This is frustrating for patients and may be one of the reasons for the surging popularity of alternative medicine whose practitioners often make dramatic claims for the safety and benefits of their treatments.

Perhaps the most subtle and easy to take on brilliant disguise is the one which is encouraged by the very structure of the doctor-patient relationship. We see people at their most vulnerable and they see us in our most competent mode. We see them when they are troubled, hurting and confused. They see us when we are in our element: our offices, our hospital, our space. We are the expert and they are the needy. It is easy to begin to believe that perhaps we are different creatures; that we are some superior being and they some inferior being. It is attractive to forget (or deny) our own shortcomings, areas of incompetence and hurts. But it is these parts of us that make us human, and in the long run they can be sources of wisdom, humility and connection. Keeping in mind the wholeness of our patients (though we may only see a part) and owning our own humanity can help keep the doctor-patient relationship healthy.

The next song after "Brilliant Disguise" on the Springsteen CD is "Human Touch," and that's certainly an essential part of being a physician. ■



**Patients may invite  
us to wear the mask  
that fulfills their  
fantasy of the  
perfect doctor, and  
sometimes their  
invitation can be  
quite persuasive.**



*We're known for our abilities...*

# Flexibility.

We know you have a choice about your healthcare plan. That's why we offer the flexibility you want so you can get the care you deserve. We are Arkansas people working to take care of your health — we're Arkansas Managed Care Organization (AMCO).

# Accountability.

Our statewide PPO network offers community care through:

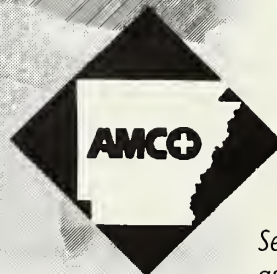
- More than 3,800 physicians and hundreds of other healthcare professionals;
- Services in over 100 hospitals; and,
- An excellent staff representing your best interests.

# Stability.

AMCO is a recognized leader in managed healthcare in Arkansas, not only because of our size, but also for our high degree of accountability, outstanding customer service and stability.

Call us today at  
**1-800-278-8470** or  
**501-225-8470.**

#10 Corporate Hill Drive, Suite 200  
Little Rock, Arkansas 72205  
[www.amcoppo.com](http://www.amcoppo.com)



*Serving employers and their greatest asset with quality managed care.*

Putting the *Care* back in Managed Health*Care*





## The AMS Health Benefit Plan — a Eulogy

BY DAVID WROTEN

**W**hile our title for this month's article may sound ominous, remember that the word "eulogy" is synonymous with "praise." The difference, of course, is that praise is usually given to someone still with us, while a eulogy is reserved for someone who has died. However, in this case the eulogy is not for a person.

For the past eight years, physicians and their employees have reaped the benefits and cost savings from an AMS sponsored health insurance program known as the AMS Health Benefit Plan. The continuation of this program is in doubt due in part to the take-over of American Investors Life Insurance Co. by the Arkansas Insurance Department.

In 1992-1993, the AMS created the plan as a self-funded, group health program. There were good reasons. Many carriers had stopped writing small employers. The vast majority of clinics fall into this "small employer" category with two-nine employees. Some carriers were actually avoiding medical clinics on the assumption that physicians and their employees overuse services. Health maintenance organizations were beginning to market exclusive provider health plans, and clinics were looking for alternatives. In 1995, the AMS plan became fully insured through American Investors, and by the year 2000 had grown to include 90 clinics, more than 2,000 employees and family members.

The plan was designed to succeed. While similar to a "standard" insurance plan, it differed in several ways. For example, the benefits were customized for physician clinics, small clinics were not automatically charged higher premiums and claims experience for the AMS plan was reviewed separately from the carrier's other business. These factors had a major impact on the premium savings enjoyed by the plan participants. However, the single most important benefit was not cost but service.

The AMS created a wholly-owned subsidiary, AMS Benefits, to market and service the insurance program. Not only did AMS Benefits market the plan, it conducted the enrollments, responded to most customer service calls, did the billing and served as the repository for all claims. Except in cases involving legal determinations, participants never had to call the carrier. In today's high-tech world of automated phone systems and anonymous customer support staff, our participants enjoyed the benefit of only having to call one person and always knowing that person by first name.

The take-over of American Investors was unfortunate yet unavoidable given the multitude of problems that have plagued the carrier for the last couple of years. In anticipation of such an event, AMS Benefits searched to no avail for a year to find a carrier that could duplicate the success of the AMS Health Benefit Plan.

With the possibility that American Investors will be liquidated, AMS Benefits has obtained agreements with several carriers to separately quote each clinic. Most will see their premiums go up, especially small clinics with two-nine employees. Some of the large clinics may actually have difficulty obtaining other coverage. Certainly, the specialized benefit design and cost savings will be gone.

The passing of the AMS Health Benefit Plan is not unlike the death of an old friend. We often fail to appreciate their true value until they are gone. However, by continuing to use AMS Benefits as their "agent," clinics will still have the support and assistance they have come to expect, and after the turmoil has passed, we can hopefully begin looking for innovative ways to develop a new association plan. ■

**You can care for your patients while we take care of business.**

*Discover the benefits of ESA's integrated business services for healthcare professionals.*

- **Payroll Services**  
complete payroll management.
- **Human Resources**  
regulatory compliance management.
- **Comprehensive Benefits Package**  
health, dental, vision, 401K
- **Customized Consulting Services**
  - Employee Selection & Training-  
Ensure you have the right team.
  - Budgeting and Planning-  
Develop a business plan that works for you.
  - Billing- Turn key service.



**(501) 225-7300**  
**1-800-344-5551**

## Growth of Your Retirement Investments Is Our Specialty

**SEP IRAs**  
**IRA Rollovers**  
**401Ks**

Using  
**The Optimum Performance Strategy**  
**TOPS**

The Unique Investment Program Developed by  
Tom Schallhorn.



**SOUTHWEST CAPITAL MANAGEMENT, INC.**

REGISTERED INVESTMENT ADVISOR

Thomas N. Schallhorn, President  
501.374.1119 • 1.888.440.9133  
105 West Capital Avenue, Suite 101  
Little Rock, AR 72201-5732



# Vice President Pushes for Patients' Bill of Rights

*Local Physicians Share Stage with Al Gore at UAMS Campaign Stop*

BY NATALIE GARDNER

**D**r. Denise Greenwood, a breast surgeon in Little Rock, recently joined Vice President Al Gore on a University of Arkansas for Medical Sciences' stage to address the need for a Patients' Bill of Rights. A bipartisan version of the bill passed the House of Representatives and is one vote away from achieving majority in the Senate.

Dr. Greenwood told a personal story of a patient denied care by a health maintenance organization and voiced her concern for medical decisions made by insurance accountants.

"I was too naive when I left my training here at UAMS," Dr. Greenwood told an audience of about 600 July 11. "I left the safety of that and am now being dictated how to take care of patients by insurance companies."

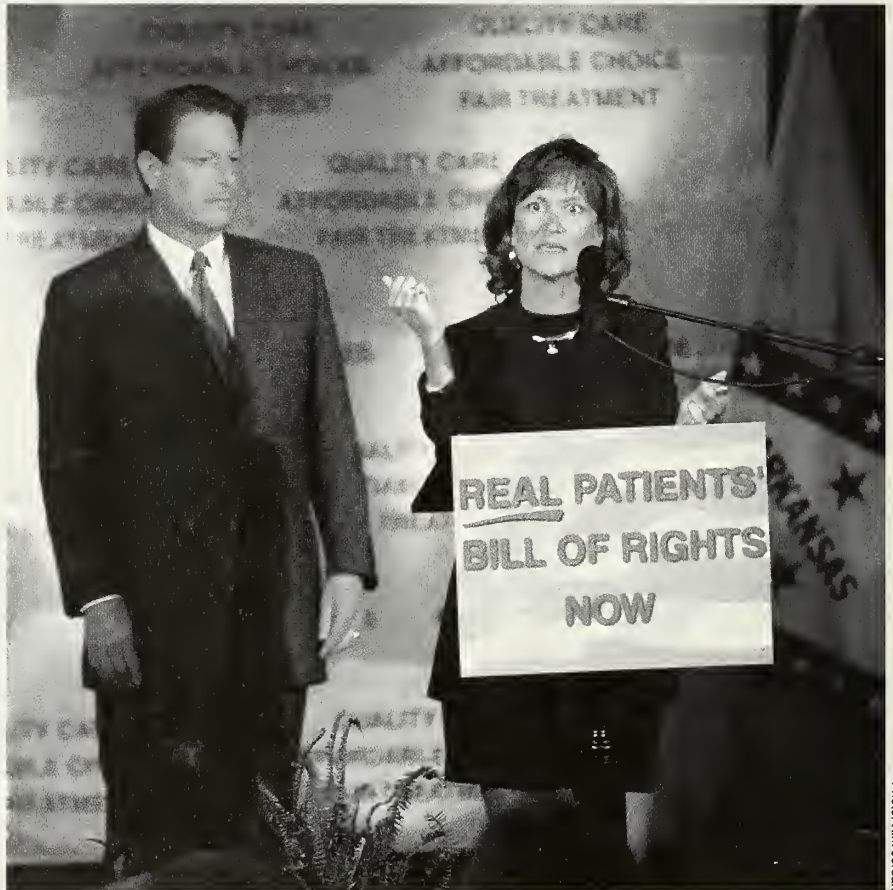
"We have got to get back to letting the patient and the physician decide what needs to happen. We need to be able to individualize medicine based on appropriate uses."

With a stage full of physicians sitting behind him, Gore told the audience if elected president he would fight the "Do-Nothing Congress."

"It seems to me to be a no-brainer,"

## **Gore is in favor of the bipartisan Norwood-Dingell bill that includes:**

- Protections for all Americans in health plans;
- Protections from financial sanctions for patients accessing emergency room care;
- Access to health care specialists and clinical trials;
- Access to a fair and timely appeals process to address health plan grievances; and
- Enforcement mechanisms that ensure recourse for patients who have been harmed as a result of a health plan's decision.



*Presidential candidate Al Gore and Little Rock breast surgeon Dr. Denise Greenwood speak out for patients' rights.*

Photo: Kirk Jordan

Gore said. "After all the training doctors and nurses have acquired, then to have their carefully prepared decisions casually overturned by an accountant, it's outrageous."

"These financial people don't have the right to play God."

Gore said the federal government shouldn't put doctors in a position of having to deceive insurance companies to

get care for their patients.

"We shouldn't have a situation that requires national media coverage on a case-by-case basis [to get the right decision made]," he said.

Gore blames the bill not passing because of special interest money influencing leaders of Congress.

"It is time for Congress to serve the people, not the powerful," Gore said.

Gore ended his speech with a Q&A session featuring several insurance company horror stories told by physicians in the audience. ■

BY CHRISTY L. SMITH

**W**omen have always played an integral role in the medical profession. Albeit, for much of history, women served as midwives, nurses and holistic healers; the role of physician was closed to women.

But in the last three decades, the profession has experienced a surge of women physicians. According to the American Medical Association, the number of women practicing medicine in this country has increased nearly sevenfold — from 25,401 in 1970 to 177,030 in 1998.

September celebrates those women and their growing number of achievements in the medical field. Indeed much has changed since Elizabeth Blackwell applied to medical school in 1874 and was accepted because the faculty and student body at Geneva College (now Hobart and William Smiths College) in New York thought her application was a joke.

The number of women applying to medical schools across the country has increased dramatically from 2,289 in 1970 to 17,787 in 1998, according to the AMA. And that trend has carried itself out in Arkansas, as well.

“When I was a freshman in medical school in 1972, there were very few women in the classes. It has certainly increased,” said Dr. Richard Wheeler, executive associate dean for student and academic affairs at University of Arkansas for Medical Sciences.

Dr. Wheeler, who assumed his administrative role at UAMS 11 years ago, said the percentage of women in medical school classes has “remained stable” at about 40% during the last few years.

According to Tom South, director of admissions at UAMS, the number of women entering medical school at UAMS in 1970 was 17, or 14% of the class of 124 students. In fall 2000, that number will be 55, or 37% of the class of 150, he said.

And women physicians are now venturing into specialties that have long been dominated by men, Dr. Wheeler said.

“The biggest change I’ve seen is that there has been a dramatic shift in the number of women going into OB/GYN and the number of women in the

# No Longer A Man's World

## Women Continue to Move Medicine Forward

general public who want to go to a woman gynecologist,” he said.

According to the AMA, 12,885 women physicians specialized in obstetrics and gynecology in 1998. Only 1,337 women practiced OB/GYN in 1970.

Other specialties have seen similar increases, according to the AMA. For instance, women specializing in internal medicine jumped from 2,383 in 1970 to 33,307 in 1998; and women practicing pediatrics rose from 3,816 in 1970 to 26,752 in 1998.

Changing attitudes about women’s abilities have probably attributed to the trend, Dr. Wheeler said.

“If I had to guess, I would say that it is the result of a general attitude that women have as much right in the profession and do as well in the profession as men,” he said.

That’s a far cry from the attitude that greeted Blackwell when she graduated — with honors — from medical school in 1849. The first woman to receive a medical degree in the United States moved to England to study in hospitals that were more accepting of her. In 1851, Blackwell moved back to New York to begin a private practice. Because male physicians refused to work with a female associate, Blackwell opened her own hospital for indigent women and children in a New York City slum. That hospital still operates today as New York Infirmary-Strang Clinic.

When a female friend suggested to Blackwell later in her life that women should continue to occupy a secondary role in the medical profession, Blackwell replied that she did not strive to give women a primary or secondary role in the field, just the freedom “to take their true place, wherever it may be.” ■



# Dr. Susan Ward-Jones

## Internal Medicine/ Rural Health

BY CHRISTY L. SMITH

**A**t the age of 8, Dr. Susan Ward-Jones already was making hospital rounds. The 35-year-old medical director of East Arkansas Family Health Center in West Memphis remembers being dropped off after school at Helena Hospital, where her mother worked as a registered nurse. She passed the time by accompanying doctors on their rounds.

"I have always wanted to be doctor. My mother would always say, 'If you can be a nurse, then you can certainly be a doctor.' I have the utmost respect for nurses, but I didn't like the idea of emptying bed pans [for a living]," she laughed.

Now married to state Rep. Steven Jones and expecting her first child in February, Dr. Jones received a bachelor of science degree from Dillard University in New Orleans. She graduated from University of Arkansas for Medical Sciences in 1993 and completed an internal medicine residency there. She is the only full-time physician working at East Arkansas Family Health Center. Two part-time physicians and three nurse practitioners help care for the indigent patients there. Many of Dr. Jones' patients cannot even afford the \$15 it costs to visit the clinic, she said.

"We are in the Delta, one of the poorest areas in the state and probably one of the poorest in the nation. We see patients every day who have to make a decision. Are they going to buy their medicine, or are they going to pay their light bill?" she said.

**"MY MOTHER would always say, 'If you can be a nurse, then you can certainly be a doctor.' "**

Most patients lack the job skills or education to make a decent living.

"Most of them spent their whole lives working on farms, but farmers don't need them to pick cotton anymore because machines can do that. So what do you do if you can't read or write and all you've done is work on the farm?" she said.



Dr. Jones relies on donated medicine and specialists' services to help ease the financial burden on these patients, most of whom can be referred to Memphis' Baptist Hospital, which Dr. Jones compares to University Hospital in Little Rock.

"We all have to work in a concerted effort to take care of the patients," Dr. Jones said. But working at East Arkansas Family Health Center means that Dr. Jones has to fill many more roles than just that of a physician.

"There's a big difference between working here and being in private practice. You have to be an activist. You have to be a social worker. You have to be a friend. My job is not just to diagnose and write a prescription for somebody. In my clinic, I have to ask [if the patient is] going to be able to get this prescription," she said.

And underlying problems often prevent the patient from taking his medicine properly, if he is able to afford it at all, she said.

"The illiteracy rate here is astounding. When [patients] aren't taking their medicine right, you question if they can

**Dr. Jones is more than a physician at her East Arkansas health clinic. She's a friend, a social worker and an activist.**

read the label," she said.

HIV and AIDS also is something that Dr. Jones deals with on a daily basis. Crittenden County ranks third in the state for the number of reported HIV and AIDS cases, according to the Arkansas Department of Health's HIV/AIDS Surveillance report printed in last month's *Journal*.

A Title II grant that Dr. Jones secured in 1998 allows her to provide medical and social services to about 150 patients suffering from the deadly disease.

But Dr. Jones doesn't mean to leave the impression that she's bitten off more than she can chew. In fact, she would recommend working in this setting to future physicians.

"I'm glad I had the chance to come here fresh out of my residency. [In school], we are not taught anything about the business aspect of medicine," she said. At the clinic, Dr. Jones said she is able to interact with financial, insurance and medical department staff members who are teaching her the ropes in case she decides to go into private practice.

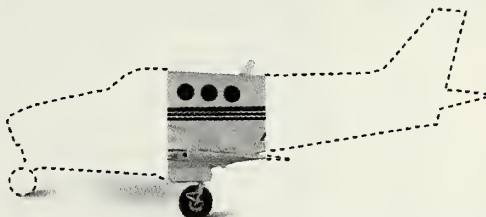
"Coming back here has been rewarding. It has made me appreciate more of what I have and not to complain so much, but I won't say that I will be here for the rest of my career," Dr. Jones said.

Dr. Jones was appointed in April 1999 by Gov. Mike Huckabee to serve on the Governor's Alliance for Regional Excellence, a committee comprised of leaders from southwest Tennessee, northern Mississippi and northeast Arkansas who are charged with developing a plan to improve the health and economic conditions of that tri-state area. She also was appointed to the state Board of Health in October 1999.

Dr. Jones is a member of the Arkansas Medical Society and has participated in the Doctor of the Day program, volunteering her medical services to state lawmakers during the legislative session of 1999.

She said that the Medical Society has well-served its purpose as an "advocate for physicians," keeping physicians across the state informed of the laws that affect them and their practices. ■

**FLY THIS MUCH**



**BUY THIS MUCH**



With fractional ownership from Central Flying Service, you get more than you pay for.  
Bonanza A36, Baron 58  
King Air C90B.



For more information about what **SKYSHARE** can mean to you call Cheri McKelvey at 375-3245 x321

# Need to Brag?

Let your peers  
and colleagues know:  
**Top-Flight Hospital Services,  
New Hires & Associates,  
Promotions,  
Honors & Awards.**

**THE  
Journal**  
OF THE ARKANSAS MEDICAL SOCIETY

**For Advertising Information,  
Contact Stephanie Hopkins  
501-372-2816 ext. 293.**



# Dr. Sandra Marchese Johnson

## Dermatology Research

BY NATALIE GARDNER

**D**r. Sandra Marchese Johnson loved her residency in dermatology at the University of Arkansas for Medical Sciences, but is glad to now be a part of the “real world.”

Her residency ended June 30, and July 1 marked Dr. Johnson’s first day as an assistant professor at UAMS and director of the school’s clinical trials unit in the department of dermatology. As a young doctor, Dr. Johnson has enjoyed a true diversity when it comes to her medical education. In medical school, the ratio of women and men was about 50/50, and in residency, Dr. Johnson worked with more women physicians than men.

“We owe a lot to the women who came before us,” Dr. Johnson said. “I still have some patients who think I’m the nurse, and some still want a male physician, but 95% of the people I treat are fine with women physicians.”

Dr. Johnson, who is expecting her first child in January, is keenly aware of the hurdles many women face.

“Women in medicine face the same things women in other careers face — juggling being a wife, mother and a professional,” she said.

Dr. Johnson always knew she wanted to be a doctor. Raised in a blue-collar family, she wanted to use her intelligence and talent to help others. She attended a six-year undergraduate/

Photo Kirk Jordan



**Dr. Johnson spends time in west Little Rock at UAMS’ new cosmetic and laser surgery center.**

**“WE OWE a lot to the women who came before us. I still have some patients who think I’m the nurse, and some still want a male physician.”**

medical school program in Ohio and decided to specialize in dermatology during her second year in medical school.

“With dermatology, you see patients of all ages,” she said. “Also, the skin tells you everything that is going on; you can see things getting better or worse. The skin also can tell us when something is wrong on the inside, such as cancer or diabetes.”

In 1996, UAMS’ dermatology program was one of eight programs that was a four-year residency, integrating internal medicine with dermatology. Dr. Johnson was eager to get in the program, and immediately found a passion for research. As the director of the department’s clinical trials unit, Dr. Johnson oversees seven research programs. One of the largest projects is a study of the treatment of warts. The research includes using immunotherapy to rid the body of the virus that causes warts.

Aside from overseeing numerous clinical trials, Dr. Johnson also spends time in west Little Rock at UAMS’ new cosmetic and laser surgery center. She helps patients with tattoo and age spot

removals, hair removal and chemical peels.

“I really like the cosmetic side of dermatology,” she said. “I enjoy being able to use new treatments and be on the cutting edge.”

And staying active in organized medicine keeps her on the cutting edge too, Dr. Johnson said. Although busy in the academic life, Dr. Johnson feels it’s important for her to

stay active in groups such as the Arkansas Medical Society and the American Academy of Dermatology. This year, she will serve as the alternate delegate to the American Medical Association for the AAD. During her resident years, Dr. Johnson was a strong voice for AAD residents across the country, serving as the chairman of the Residents and Fellow Committee in 1999. This year, she was awarded the Presidential Citation for Young Physicians in Dermatology by the AAD.

"With the AAD, I was able to really see how one person can make a difference," Dr. Johnson said. "We're looking at managed-care issues, billing issues, patient education. Our biggest issue right now is the Patients' Bill of Rights."

"With the AAD, I was able to really see how one person can make a difference. We're looking at managed-care issues, billing issues, patient education. Our biggest issue right now is the Patients' Bill of Rights."

Dr. Johnson said women are gaining more and more power on the political front, too. There are more women serving as committee chairmen and officers in the American Medical Association.

As for her service in Little Rock, Dr. Johnson said she plans to stay in the research field, challenging herself with new cases.

"I'll be here for a long time," Dr. Johnson said. "I like the academic environment, and I like where I work. Unlike other physicians, we get to use medicines that are a bit more risky and not always available to the public yet." ■

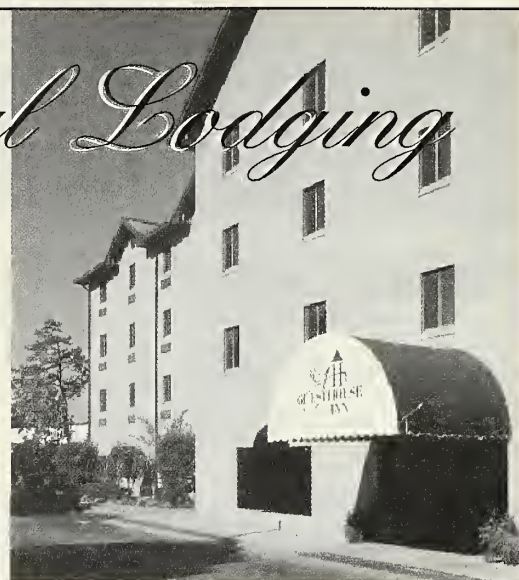
## Medical Lodging

*Close proximity to all  
Little Rock hospitals*

Serving Little Rock Visitors

- Medical stays
- Business travel
- Leisure travel

*"Guesthouse Inn is your  
perfect home away from home  
while in Little Rock"*



301 So. UNIVERSITY AVE. ▲ LITTLE ROCK, AR 72205 ▲ (501) 664-6800

## Board Certified Emergency Physicians needed in Central Arkansas

ARE YOU TIRED?  
ARE YOU LOOKING  
TO SLOW DOWN?

We need you in our soon-to-be renovated 11,000 volume ED in central Arkansas. BC Emergency Medicine staff physicians and a Medical Director are needed. Remuneration is \$100.00/hr., procured mal-practice and Independent Contractor status. Please contact **Traci Mahlmeister** with PhyAmerica at **800-476-5986**, fax CV to **919-382-3274**. All inquiries are confidential.



**PhyAmerica**  
Physician Services, Inc.



# Dr. Sidney Hayes

## State Medicare Medical Director

BY NATALIE GARDNER

**S**ince January, Dr. Sidney Hayes has been sitting in her office atop the USAbile building, looking out on downtown Little Rock and smiling.

Before January, Dr. Hayes barely had five minutes in the day to stare out the window and contemplate her life. As the state's Medicare medical director, Dr. Hayes now has an 8-to-5 job that leaves her time to go to her son's baseball games, read, collect Star Wars toys, go to bed at a decent time and play in a rock 'n' roll band. Before joining Arkansas Blue Cross and Blue Shield, the insurance provider that has the state's Medicare contract, Dr. Hayes was a pulmonologist in private practice for 15 years. When in practice, she juggled raising three children, 17, 18 and 23, as a single mom with night and weekend call.

"I was so tired and needed some rest, so this was a good move for me," Dr. Hayes said.

As medical director, Dr. Hayes oversees Medicare policy and data analysis. Her department is constantly running data on Medicare providers, looking for fraud and abuse.

"The system kind of drives itself," Dr. Hayes said. "There's a set of numbers and codes, and we're looking for any statistical changes."

Dr. Hayes spends a good amount of time forming state policy to fill the gaps when there are no national regulations in place. When new procedures are developed, Dr. Hayes and her staff decide how and if Medicare will pay for it.

**"THE MOST important thing is to keep our communication with providers open. We want them to know we're not out to get them."**

"A typical day for me includes exchanging a lot of e-mails with medical directors across the country," she said. "We also have many provider inquiries about coverage and how to bill."

Making exceptions for certain cases is always hard, Dr.



Photo: Kirk Jordan

Hayes said. If a provider calls with a particular problem and is wanting Medicare coverage, Dr. Hayes and her staff have to carefully consider the situation.

"The most important thing is to keep our communication with providers open. We want them to know we're not out to get them. Our job is to protect the Medicare trust fund."

Dr. Hayes said fraud and abuse is no more in Arkansas than anywhere else. If there is a problem nationwide, Dr. Hayes often sees it here too.

"We're not any worse than any other state," she said. "I'm very pleased with the medical community here." Although she is a woman, Dr. Hayes said she garners

**When she's not overseeing the state's Medicare program, Dr. Hayes practices with her rock 'n' roll band.**

the same respect from the physician community as any man.

"I haven't had any prejudice in my career," she said. "The medical director of the Health Care Finance Administration is a female. Donna Shalala [U.S. secretary of health and human services], who is over her, is a female. The top three people in this area are all female. I don't think there's any difference as long as you do the work."

When Dr. Hayes informed her parents she wanted to be a doctor, they were skeptical. She was the first person in her family to go to college, and Dr. Hayes' mother thought she might be doing a "man's job."

"My parents had mixed feelings," she said. "I was going to go into nursing, but took the MCAT on a lark during my senior year, and applied to medical school."

But Dr. Hayes is quick to recognize everyone's talents, not just women.

"You want anybody to be successful, not just women," she said. "If we only helped women, we'd be like the thing we are trying not to be. That's real important. I don't think it was harder being a woman in medicine. Whoever the best qualified is, that's the important thing."

As a respected and busy pulmonologist in Little Rock, Dr. Hayes didn't have a lot of free time to keep up with medical issues. That's where the Arkansas Medical Society helped.

"When you're in practice, you depend on the Medical Society to look out for your best interest," she said. "I didn't have time to follow that, with a full-time practice and three kids. They are great about disseminating information we need."

Now, with more time on her hands, Dr. Hayes spends every Monday night practicing with her band, made up of eight physicians who are all in their early 50s.

"We play bar mitzvahs, birthdays, you name it," she said. "It's like being 20 all over again." ■

## There are plenty of full service banks. So where are all the full service bankers?

If you want the type of personal service that's missing from most full service banks these days, call Metropolitan National Bank's Professional Banking Group. Our highly specialized team, led by Senior Vice President George Penick (978-7632), focuses exclusively on helping those with substantial assets, but limited time to maximize their potential.

Just make the SimpleSwitch to our Professional Banking Group at Metropolitan. We'll give you the personal service you've been looking for.



# Metropolitan National Bank

Little Rock, North Little Rock, Sherwood,  
Benton, Bryant and Conway

N E A R B Y & N E I G H B O R L Y.

[www.metbank.com](http://www.metbank.com)

Member FDIC



## Helena Regional

M E D I C A L C E N T E R

Helena Regional Medical Center a 155 bed JCAHO accredited facility located in Eastern Arkansas currently has two full time openings in the Radiology Department. Applicants must be registered or registry eligible for the American Registry of Radiologic Technologist (ARRT). Applicants must be well organized, people oriented, and able to work independently. Flexibility needed to rotate schedule on call. CT/ Radiology Tech-CT registry with 1-2 years experience preferred. Mammography/ Radiology Tech-Mammography experience required with other areas of experience a plus. Working knowledge of imaging equipment and procedures and proven technical expertise in breast imaging essential. ACR/ FDA accredited in Mammo & Biopsy required. We offer competitive salary with benefits. If you meet the above qualifications and would like to join our family, please submit resume to:

**Human Resources PO Box 788  
Helena, AR 72342  
EOE / Drug Free Workplace**



# Dr. Sue Chambers

## Pediatrics

BY CHRISTY L. SMITH

**W**omen now entering the medical profession would do well to listen to the advice of Dr. Sue Chambers. The gentle-mannered assistant professor of pediatrics at the University of Arkansas for Medical Sciences has weathered many storms during her 40-year career. She overcame the prejudices of medical school professors who claimed women students took up class slots better filled by men, and she devoted her life to caring for ill children in Boone County while raising her own four children.

"I won't say that I haven't made mistakes because I have," she said. "I was lucky. I had support."

Dr. Chambers grew up in Gurdon, the oldest of four children. Her father and grandfather, both doctors, culled her interest in medicine. She graduated from Hendrix College in 1960 and was one of four women to graduate from UAMS' class of 1964, with a total of 75 students.

Dr. Chambers and her husband, Dr. Carlton Chambers, met during their first year of medical school and married soon thereafter. Pregnant when she graduated, Dr. Chambers planned to take a year off before seeking an internship in San Diego, where her husband was stationed in the U.S. Navy. But their first child, who was born prematurely, died. Dr. Chambers said she then stumbled into pediatrics.

"Pediatrics was not a popular specialty then, and I didn't have anything lined up for that year," Dr. Chambers said.

Dr. Chambers completed her internship in pediatrics at

**"I WON'T say that I haven't made mistakes because I have. I was lucky. I had support."**

San Diego County General in 1965. She finished one year of her residency at the same hospital before taking two years off to have two children.

In 1968, the Chambers family moved to Little Rock, where Dr. Chambers completed two more years of her residency at UAMS. Her husband began an ear, nose and throat residency there.

In 1969, the family moved to Shreveport, where Dr.



Photo: Kirk Jordan

Chambers completed the final year of her residency and taught at Louisiana State University.

"[Today's] students can't move around as much now as I did then.

The only reason I was able to find

residencies in all those places is that not many people wanted to be a pediatrician," she said.

In 1973, the family moved once more — to Harrison.

"At first I tried to limit my work to school hours [so she could be home

with the children]," she said.

Extended family members and understanding employees helped care for the Chambers children during those erratic years. One time, a patient's mother even babysat while Dr. Chambers tended to the patient.

When her two youngest children turned 13, Dr. Chambers began a full-time private practice, but the schedule almost forced her into early retirement.

**Dr. Chambers has watched as attitudes toward women physicians have turned 180 degrees.**

"The winter before I left, I worked an average of 14 hours a day, seven days a week. We lost some family practice physicians in the area, and I had to take on more children," she said.

Relief came in 1998, when Dr. Chambers' husband accepted a faculty position at UAMS. She took an assistant professor post, which allows her to work from 8 a.m.-5 p.m. most days and frees up her weekends.

"I wasn't able to help my daughter with her children [when they were smaller], but now I keep the grandchildren on the weekends," she beamed.

Dr. Chambers marveled at how much the medical field has changed over the last 40 years, particularly in its attitude toward women physicians.

"A lot of things have been done to accommodate the married woman. New mothers [students and residents included] get six weeks maternity leave. The fathers even get a few days off," she said. "If I had had a baby when I was in medical school, I would have been expected to repeat a

year if I took time off. Now mothers can leave and pickup where they left off."

Dr. Chambers concedes, however, that it remains difficult for women physicians to juggle family obligations with a successful career, and she often tells female students "to just look at the situation available and make the best possible solution to their problem."

"Everybody has to solve that problem in their own unique manner ... Be flexible. Don't look at something and say you can't handle it because you never know what solution will present itself," she said.

Dr. Chambers and her husband maintain a home in Harrison and plan to retire there to be near their pharmacist daughter. All three Chambers' boys have chosen arts-related careers — one is a dancer in New York, another will earn his doctorate in medieval drama at Trinity College in Dublin, Ireland, this fall, and the third is a business manager for a Fayetteville advertising firm.

Dr. Chambers was a long-time member of the Boone County Special Services School Board and the Health and Social Services Advisory Committee for Headstart. She was appointed to the state Medical Board in 1998 and is a member of the Arkansas Medical Society.

She noted that women have become more active in the Medical Society over the last 40 years.

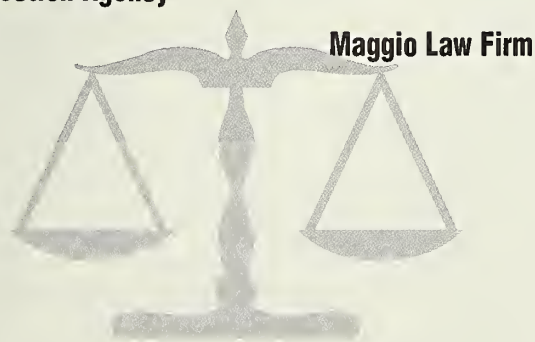
"The Medical Society is one of the last venues that women have become active in because they have been trying to gain more credibility and success in their careers. ... [And] we haven't made a drastic change, but we have made the society more community-minded. The society has always been interested in the health of our patients, but women have probably gotten the society more interested in family matters such as battered women, children and youth," she said.

Dr. Chambers predicts that women will continue "to be very active and influential in the society." ■

## Collect Bad Debt

- Cheaper
- Faster
- In compliance with the Law

Collection Agency



# MAGGIO LAW FIRM

*your collection law firm*

2843 Prince Street., Conway, AR 72033 501-327-4340  
303 N. Spruce Street, Searcy, AR 72143 501-279-2769  
[www.ebaddebt.com](http://www.ebaddebt.com)

If you've always used a collection agency. . . WHY?

Cut out the middle man by retaining the Mike Maggio Law Firm.

Save time. Save money.  
Be in compliance with the law.

Have you always used a collection agency because "that's the way you've always done it?"

*Try a new way. . . tip the scales in your favor, call Mike Maggio today.*



# Dr. Brenda Powell

## Obstetrics and Gynecology

BY CHRISTY L. SMITH

**D**r. Brenda Powell has lost count of the number of babies she's delivered during her 20-year career as an obstetrician and gynecologist at Physicians for Women in Hot Springs.

"After 20 years, it must be more than 2,000," she said, her eyes widening as the impact of that statement begins to sink in.

An inches-thick photo album and framed photographs displayed on the credenza in her office keep many of those babies at the forefront of Dr. Powell's memory, and returning patients often bring their children in to meet the doctor who delivered them.

Born and raised in Harrison, the 52-year-old physician attended Arkansas Polytechnic College (now Arkansas Tech University) in Russellville and the University of Arkansas at Fayetteville before earning a bachelor of science degree in biology and chemistry in 1976 from the University of Arkansas at Monticello. She moved around because her husband's work as an Episcopal priest demanded it. Fess Powell is now retired.

"There were times I didn't think I would get enough credit hours in one place to graduate," she said.

But Dr. Powell graduated cum laude and entered the University of Arkansas for Medical Sciences in fall 1976. Dr. Powell said she had nothing but support from her husband during her grueling four years of medical school.

"He got out a clip board and pen and asked me to show him how to use the washer and dryer. He stood there and

Photo: Kirk Jordan



**Dr. Powell was the only woman in her 1980 medical school class.**

**"YOU NEVER come to the office and feel like you're doing the same thing."**

wrote it all down [because] he knew somebody had to do his laundry, and it wasn't going to be me for awhile," she laughed.

The only woman in UAMS' class of 1980, Dr. Powell said she also enjoyed support from medical school professors and classmates. In fact, "if I did my job, I always had a friendly reception," she said.

Dr. Powell completed an OB/GYN residency at UAMS

in 1984 and immediately went to work with a colleague at Physicians for Women. She now works with three physician partners and two nurse practitioners. Dr. Powell said she

loves obstetrics and gynecology because it is an all-encompassing specialty that allows her to perform everything from general care to surgery.

"You never come to the office and feel like you're doing the same thing," she said.

In addition to her daily roster of about 30 patients, ever-changing technology and managed care keep Dr. Powell on her toes.

"The medicine we practice today is not the medicine we practiced 20 years ago," Dr. Powell insisted.

Ultrasound, which today produces a near portrait of the baby, could only determine whether a baby was breached 20 years ago, and Caesarean sections and epidurals are more common today, Dr. Powell said.



But attitudes about child birth also have changed. It is now common for extended family members to witness the birth, and the father-to-be is always in the delivery room when his child is being born.

"I hardly ever have one pass out anymore," Dr. Powell laughed.

To keep up with the changes in her profession, Dr. Powell attends continuing education classes and professional conferences — nearly 60 between 1987 and 1999.

But those classes rarely prepare her for the problems associated with managed care. Dr. Powell said she is often caught between increasing the quality of a patient's life and what an insurance company will pay for.

"A good example is a woman who needs a hysterectomy just to have a better quality of life. The insurance company doesn't consider the situation life-threatening, so many obstetricians find themselves in the way of the insurance company," she said.

The Arkansas Medical Society has proven to be an invaluable advocate

"I go to meetings now, and I see all kinds of people in all kinds of dress. The Society really represents a whole spectrum of people now."

for physicians, particularly in the face of increased scrutiny from managed care organizations, Dr. Powell said.

And the Society's willingness to grow and change over time has lent it more credibility with the physicians it serves, she said.

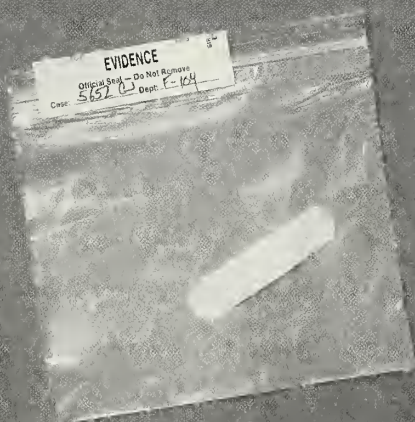
"I remember my first [Medical Society] meeting at the Arlington Hotel [in Hot Springs]. I was one of two women physicians in the room. Every man had on a dark suit and tie and stood up anytime a woman walked into the room," she reminisced.

Dr. Powell said she met "a whole bunch of people" who made her feel welcome that day, but she's glad the Society has become more inclusive.

"I go to meetings now, and I see all kinds of people in all kinds of dress. The Society really represents a whole spectrum of people now," she said.

Since joining the Medical Society in 1985, Dr. Powell has served as a district councilor, second vice president and vice speaker to the House of Delegates. She also is a member of the Garland County Medical Society, the American Medical Association and a diplomate to the American Board of Obstetricians and Gynecologists.

Dr. Powell said her work schedule is never normal, and she still gets phone calls in the middle of the night. But her never-complaining husband and the occasional post-birth cigar make it all worth it, she said. ■



## Exhibit A:

Adhesive bandage, which plaintiff alleges defendant pulled rapidly from skin, violently tearing three hairs from plaintiff's arm, which resulted in severe shock, trauma, disfigurement, chronic debilitating pain and permanent psychological damage.

To protect your reputation, we take every claim seriously.

Even the most absurd claims can be damaging if they're not handled properly. Which is why the full weight of our more than 60 years of experience in medical liability insurance is brought to bear on each and every claim, no matter how frivolous that claim may appear. In fact, when appropriate, we have appealed cases all the way to the United States Supreme Court, at no additional cost to policyholders. Because you can't put a bandage on a damaged reputation.

**The St Paul**

©2000 St. Paul Fire and Marine Insurance Company  
Coverages underwritten by St. Paul Fire and Marine Insurance Company or another member of The St. Paul Companies  
[www.stpaul.com](http://www.stpaul.com)



# Dr. Anna Redman

## Family Practice

BY CHRISTY L. SMITH

**F**or most busy professionals, a two-week vacation brings a welcome respite from the hectic pace of their careers. But Dr. Anna Redman enjoys working vacations — ones in which she delivers medical care and evangelizes to poverty-stricken people across the world.

"I enjoy going door to door presenting the Gospel to people and learning more about the way medicine is practiced in other countries," said the 41-year-old family practice physician from Pine Bluff.

Dr. Redman and her husband of 11 years, Dr. John Redman, chairman of urology at the University of Arkansas for Medical Sciences, travel with organizations affiliated with the Southern Baptist church. The couple have been to Russia, Kenya, England and New Zealand. They leave Oct. 1 for Suriname, the former Dutch Guyana in South America.

"This is the first time we will be doing a true jungle ministry. It will be the most primitive setting we've been in. We can't shower for a week, but at least we will have drinking water," Dr. Redman said.

The Redmans will join a Southern Baptist missionary in a small jungle village about two hours from the country's capital, Paramaribo, and spend 10 days teaching basic hygiene and evangelizing to villagers.

Born and raised in Pine Bluff, Dr. Redman said she has

**"THIS IS the first time we will be doing a true jungle ministry. It will be the most primitive setting we've been in. We can't shower for a week, but at least we will have drinking water."**

always been interested in science and gravitated to medicine for the job security that it offers.

"I wanted to be able to support myself in a career that would not become obsolete," she said.

Dr. Redman earned a bachelor of arts degree in

chemistry from Hendrix College. She graduated from UAMS in 1984, one of about 20 women in a class of 140.

"I did not have a lot of female role models when I was in medical school. My college roommate was one year ahead of me, and she helped me along," Dr. Redman said.

Following an internship and residency in family practice at Area Health Education Center in Pine Bluff in 1987, Dr. Redman joined

Family Medicine Associates. She has one physician partner and sees about 30 patients a day, practicing all aspects of family medicine except surgery and obstetrics. Unlike many family practitioners, Dr. Redman also does a fair amount of counseling because she said that a

Photo: Kirk Jordan



**Mission trips to far-away lands are the norm for Dr. Redman and her doctor husband.**



"physical ailment often goes much deeper."

She said that when she began practicing medicine, her male colleagues were generally accepting of her. However, patients were sometimes leery of going to a woman physician.

"There was still some of the good-old-boy system [in the profession], but women physicians had more of a problem overcoming patient prejudices because [patients] weren't accustomed to seeing a female physician," she said.

And many male members of the Arkansas Medical Society welcomed her with open arms, Dr. Redman said.

"Dr. Crenshaw, Dr. Langston, Dr. Logan and Dr. Jim Weber [were] all people who were real supportive of women in the society," she said.

Since joining the Medical Society in 1987, Dr. Redman has served as an alternate delegate and delegate from Jefferson County, second vice president, 4th district councilor and is currently speaker of the House of Delegates. She also has chaired the Young Physicians Committee and was an alternate delegate to the AMA.

The number of female Medical Society members has increased just in the last 13 years, and Dr. Redman feels these women can help the society become more inclusive.

"Women tend to be very team-oriented and don't necessarily have to be in charge, which easily facilitates a wider variety of people being included [in the society]," she said.

But Dr. Redman's attitude of acceptance reaches beyond the scope of the Medical Society. She insists that people are basically the same whether they live in a hut in Kenya or a posh home in west Little Rock.

"In Kenya, everyone is very polite and very considerate of other people," she said.

"We often think those people have less than we do, but in a lot of ways they are richer than we are . . . [When telling them about the Gospel], their questions are the same as when we talk to people in west Little Rock. Mission work really opens your eyes to the fact that people are pretty much the same all over the world." ■

## For the Investments of your Life...



INVESTING is not "The End." Investing is "The Means." The desired end is reached by planning, growing and finishing well. Our expertise is implementing investment strategies that best empower *your* plans for growing and finishing well.

Clients include individuals, retirement plans, trusts and foundations. All enjoy a competitive fee-only service. We can add value and peace of mind to the investments of *your* life.

(Left to Right): Bill Smith, Keith McCullough, Jim Strawn and Stephen Chaffin



THE BEST CHOICE IS AN INDEPENDENT INVESTMENT ADVISOR



**SMITH  
CAPITAL  
MANAGEMENT**

Pleasant Valley Office Center  
12115 Hinson Road  
Little Rock, AR 72212  
501/228-0040 or 800/866-2615  
fax 501/228-0047

At the  
**HEART**  
of quality  
health care...




...there's  
**HealthLink.**

**HealthLink of Arkansas**  
is proud to offer:

- Convenient service
- Strong multi-payor distribution channel
- Flexible health care programs
- Well-established regional network
- Responsive local presence

**Join HealthLink Today!**  
**1-877-284-0101**

**HealthLink**  
of Arkansas  
  
Managed Health Care





# A Baseline Is Necessary

J. KELLEY AVERY, MD

At 2:30 a.m. the nurse's note described "cyanotic fingertips." While this observation was being made, the patient suddenly became pulseless and stopped breathing. Cardiac resuscitation was begun and about three minutes later her pulse returned and she spoke to her family.

The 42-year-old patient was the mother of two children, both adults. She had been complaining of "something falling out" of her vagina for more than a year. The complaint was accompanied by a feeling of pressure low in the abdomen. Her menses had become increasingly excessive for the past several months, and she was incontinent when she strained or coughed. Except for this, she felt well. She had not lost weight and had a good appetite and knew of no other problems.

She had discussed her complaints with her OB/GYN on her two visits during the past few months. The doctor did a complete physical examination and found nothing except that her cervix was visible at the vaginal introitus and that she passed some urine on straining. The examination revealed no adnexal pathology, and the uterus did not seem to be enlarged. Her annual Pap smears had been negative for years. After her surgeon discussed the options with her, they agreed that a vaginal hysterectomy with an anterior and posterior repair was the treatment of choice.

The patient was admitted to the hospital in the early morning of the day of surgery. The preoperative laboratory tests showed a WBC count of 6,700/cu mm with 58% segmented neutrophils, 7% eosinophils, 1% basophils, 31% lymphocytes and 3% monocytes. The urine was entirely negative. She was taken to surgery that morning, where a routine vaginal hysterectomy and anterior and posterior repair was done. She tolerated the procedure well and went to the recovery room with normal vital signs and was beginning to wake up.

The OB/GYN surgeon's postoperative orders included an open IV of D5W set to run at 110 drops per minute. She was given a broad-spectrum antibiotic, and Demerol was prescribed for pain. On the evening of the surgery, the patient experienced some nausea for which Vistaril was ordered as needed. The following morning the vaginal pack was removed. She continued to be nauseated and vomited on at least two occasions. Vistaril was

replaced with Valium 5 mg as needed for nausea, and morphine given for pain.

At 1:45 a.m. the surgeon examined his patient and noted that she was "very restless but breathing good. No bleeding. Appears to be having a reaction to medication." At 2:30 a.m. the nurse's note described "cyanotic fingertips." While this observation was being made, the patient suddenly became pulseless and stopped breathing. Cardiac resuscitation was begun and about three minutes later her pulse returned and she spoke to her family. She was taken to the ICU, where a consultation with a cardiologist was requested.

A short time later — perhaps 15 minutes — she had a heart rate of 140/min, was hypotensive and fine twitching of the muscles was noted. Blood taken immediately after the resuscitation showed a pH of 7.29, PO<sub>2</sub> 173 mmHg while breathing 100% oxygen, and PCO<sub>2</sub> 43 mmHg. The sodium was reported at 120 mEq/L and the potassium 3.0 mEq/L. Blood studies again obtained at 3 a.m. showed the sodium at 114 mEq/L, the potassium 2.9 mEq/L, chloride 75 mEq/L, and CO<sub>2</sub> 17. The IV of D5W was replaced with 3% sodium chloride to run 500 cc every two hours. She had received between 5,000 and 6,000 cc of the glucose solution.

By 5 a.m. the patient was unresponsive and her pupils were dilated and fixed. Two hours later the sodium was reported at 137 mEq/L. She was seen by other consultants in an attempt to evaluate the profound diuresis that occurred after the hypertonic saline. The BUN and creatinine were normal. Their collective opinion seemed not to consider the large volume of D5W she received as being significant.

After spending the next six days on a respirator, she was determined to be brain dead and life support was stopped. No autopsy was done.

A lawsuit was filed charging the surgeon with negligence in not monitoring electrolytes either before or after surgery

while giving the large volume of D5W.

### Loss Prevention Comments

During the investigation of this case, it was troublesome that the electrolytes were not routinely checked preoperatively by this surgeon, attributing the restlessness to medication without covering all the bases was an error in judgment.

From the record, it does not appear that any of the team appreciated that such a large amount of D5W had been given. There was an exhaustive investigation to rule out central nervous system disease, renal disease and the like without coming to grips with the fact that the most logical solution was water intoxication resulting in severe hyponatremia. Her restlessness was an expected reaction to this problem, and had it been correctly diagnosed and treated at that time, the outcome might have been favorable. It was the cerebral edema resulting from the hyponatremia and hypokalemia that produced the restlessness and ultimately the cardiorespiratory depression and cardiac arrest. Once the cascade of events began, it progressed rapidly, and by the time the electrolyte imbalance had been corrected, the cerebral hypoxia had exacted its toll and the patient was doomed to continue on a downhill course. One feels for the treatment team, especially the surgeon. He was at the bedside during the deterioration of his patient, focused, it appears, in the wrong direction.

Without a preoperative electrolyte study with a postoperative follow-up, the physician was in the dark. Baseline preoperative studies are essential to proper postoperative care. ■

*The case of the month is taken from actual Tennessee closed claims. An attempt is made to fictionalize the material in order to make it less easy to identify. Dr. Avery is a member of the Loss Prevention Committee, State Volunteer Mutual Insurance Co., Brentwood, Tenn. This article appeared in the August 1999 issue of Tennessee Medicine. It is reprinted with permission*

# MEDICAL OFFICE SPACE

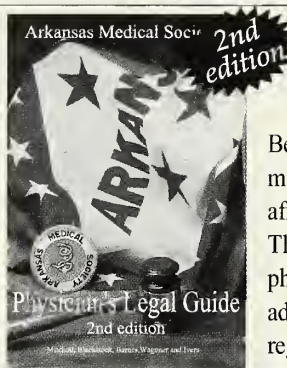
**DOCTORS BUILDING**  
500 South University Avenue  
Little Rock, Arkansas

Suites Available ranging from  
950 sq. ft. to 4,807 sq. ft.

Professional Management  
Maintenance 24 hours a day, 365 days a year  
Nightly janitorial service plus Day Maid  
Free Doctors Parking Lot -  
Or Low Cost Reserved Parking  
Free Use of Well Appointed Conference/Club Room  
Ancillary Services in Building

**Location convenient to all area Hospitals**  
including Baptist, St. Vincent Doctors,  
St. Vincent Infirmary, UAMS, VA  
and Arkansas Children's.

**CONTACT**  
**Betty Garcia - 664-1812**  
VISIT OUR WEBSITE [www.lrma.com](http://www.lrma.com)



## Arkansas Medical Society's Physician's Legal Guide

Be one of the first to obtain this guide which contains a multitude of state and federal laws affecting the practice of medicine.

This guide is a valuable resource for physicians, clinic and hospital administrators, office staff, attorneys, regulators and many others.

**\$6500\***  
for AMS  
members  
**\$8700\***  
List Price  
Prices include  
shipping and handling.

Check enclosed in the amount of: \$ \_\_\_\_\_

Please charge my Visa or Mastercard:

☐ Please check if you are  
an AMS member.

Cardholder's name: \_\_\_\_\_

Credit card No.: \_\_\_\_\_ Exp. date: \_\_\_\_\_

Cardholder's Signature: \_\_\_\_\_

Name: \_\_\_\_\_

Clinic: \_\_\_\_\_

Address: \_\_\_\_\_

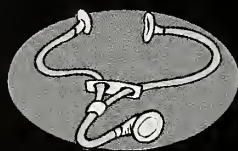
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Fax No.: ( ) \_\_\_\_\_

CREDIT CARD ORDERS CAN BE FAXED TO: (501) 224-6489

Call the AMS office at 501-224-8967 or 800-542-1058 for volume discount pricing.





## Pulmonary Hypertension in Pregnancy

STEVEN E. KELLEY, MD EUGENE S. SMITH, III, MD, EDITOR

*The combination of pulmonary hypertension and pregnancy can lead to maternal/fetal death. Pulmonary hypertension can be either primary (idiopathic) or secondary. In the case of primary pulmonary hypertension (PPH), its incidence rate is 1-2 per million. PPH tends to occur in young females between the ages of 20-40. Secondary pulmonary hypertension may be related to underlying cardiac or pulmonary disease, recurrent thrombo-embolic episodes, drugs, etc. This case highlights several important issues in the management of pulmonary hypertension during pregnancy.*

### Case Report

A 25-year-old white female gravida<sub>4</sub> para<sub>1</sub> abortion<sub>2</sub> now at 35 weeks gestation transferred from an outside hospital for further management of pregnancy complaining of worsening shortness of breath and dyspnea on exertion (DOE). The patient reports a normal vaginal delivery approximately four years ago, but since that time, she has had progressive DOE. She was seen by her local doctor shortly after delivery who attributed her symptoms to residual weight from pregnancy. She denies paroxysmal nocturnal dyspnea, orthopnea or cyanosis. During this pregnancy, she reports that her DOE has progressively worsened. On initial evaluation at the outside hospital, her oxygen (O<sub>2</sub>) saturation on room-air was in the mid 80s. This corrected to

>92% by the use of supplemental O<sub>2</sub>. At the outside hospital, an echocardiogram revealed a dilated right atrium and ventricle with severe tricuspid regurgitation and moderate pulmonary regurgitation. The estimated right ventricular systolic pressure was > 90mmHg. A bubble study was suspicious for a small patent foramen ovale.

Her past medical history was significant for obesity and exposure to hepatitis C; she had smoked one to two packs per day for the last seven years. She had no prior cardiac history and denied use of either diet pills or illicit drugs.

Physical examination revealed a young white female in mild respiratory distress. Her blood pressure was 114/60 mmHg with a pulse of 90 beats/minutes and weight of 202 pounds. Jugular venous pressure could not be assessed. Cardiac examination demonstrated a right ventricular heave, laterally displaced apical impulse. A prominent pulmonary component of the second heart sound, and a grade 2/6 systolic murmur heard best at the left lower sternal border. Lungs were clear. Extremities showed no edema, cyanosis or clubbing.

After transfer to our facilities, the patient was admitted to labor and delivery and placed on telemetry monitoring. The supplemental O<sub>2</sub> was continued, and she remained clinically stable. Laboratory evaluation revealed a hemoglobin of 14 g/dl, hematocrit of

42% and normal electrolyte panel. HIV/Hepatitis panel were negative. On hospital day four, she was transferred to the intensive care unit for induction of labor with the use of oxytocin. An arterial and central venous pressure line were placed. The patient had spontaneous rupture of the membranes, and after 3.5 hours of labor, an uncomplicated vaginal delivery of a healthy female infant. She was continued on supplemental O<sub>2</sub> and started on oral anticoagulation. The patient did well after delivery, but on post-partum day two developed increased SOB with O<sub>2</sub> saturation in the 80s on 6L. The possibility of pulmonary artery embolus was entertained but a spiral CT of the chest was negative. The patient improved and was discharged home on post-partum day four on oral warfarin and off supplemental O<sub>2</sub>. The patient was scheduled to follow-up in cardiology clinic in one month for further evaluation and treatment of pulmonary hypertension.

### Discussion

Pregnancy in the setting of severe pulmonary hypertension has been associated with a high mortality rate. In an overview by Weiss, et al<sup>1</sup>; it was estimated that pregnancy in patients with PPH had a maternal mortality of 30%. In patients with Eisenmenger's syndrome, the mortality was 30-40%, and patients with secondary vascular pulmonary

hypertension the mortality was greater than 50%. The mortality in these patients is noted to be the highest in the first 30 days post-partum.

The diagnosis of pulmonary hypertension can be delayed due to the difficulty in distinguishing symptoms from normal physiological changes of pregnancy. As with all diagnosis, a thorough history and physical is important. Some of the key features of the history include known congenital heart defects, underlying lung disease, smoking, cocaine use or use of diet drugs. In addition to the history and physical, a high index of clinical suspicion for possible underlying pathology is required.

The diagnostic work-up for pulmonary hypertension should include investigation for any possible secondary causes. The most common secondary causes are related to cardiac or pulmonary abnormalities. Echocardiography allows for assessment of underlying cardiac function, valvular abnormalities, cardiac defects and estimation of the severity of pulmonary hypertension. Other diagnostic tests includes electrocardiogram, pulmonary function tests, ventilation perfusion scan, lower extremity dopplers and drug screen. In our patient, we were not able to fully assess her for secondary causes because of her presentation late in pregnancy.

The management of these patients during the peri-partum period should be a multi-disciplinary approach, including an obstetrician, anesthesiologist and a cardiologist.<sup>2</sup> Due to the rare number of cases, there is no large randomized trial on the treatment of these patients. Physicians managing these patients would agree on supplemental O<sub>2</sub> to keep saturation greater 90%, anti-coagulation with heparin (either low-molecular wt. or unfractionated), ECG monitoring and keeping fluid balance during the pre-partum period.<sup>2</sup>

The mode of delivery (vaginal vs. cesarean section) is usually dictated by the obstetrical need. There have been reports in the literature that patients may actually do worse with cesarean section. Thus most authors advocate vaginal delivery if possible. Epidural anesthesia is most commonly used in these patients.

The use of nitric oxide (inhaled) and

prostacyclin (IV/inhaled) in the peripartum period is increasing.<sup>3,4,5</sup> Both of these vasodilating substances are decreased in patients with pulmonary hypertension due to endothelial cell dysfunction. In addition, endothelin levels are increased leading to vasoconstriction. Preliminary data with the use of these substances is promising, but their use is still in the investigational stages.

Anticoagulation should be started as soon as possible after diagnosis unless contra-indicated.<sup>1,2</sup> The use of heparin (either low-molecular wt. vs. unfractionated) in the pre-partum is usually the rule. Post-partum the patient can be changed to warfarin therapy.

### Conclusion

The combination of pregnancy and pulmonary hypertension can be lethal. The early diagnosis of this condition plays a key role in the outcome of these patients. The management of the patient requires a multi-disciplinary approach. The patient should be counseled against any subsequent pregnancy. ■

### References

1. Weiss BM, Zemp L, Seifert B, Hess OM. Outcome of pulmonary vascular disease in pregnancy: A systematic overview from 1978 to 1996. *J Am Coll Cardiol* 1998;31:1650-7.
2. Smedstad K, Cramb R, Morison D. Pulmonary hypertension and pregnancy: a series of eight cases. *Can J Anaesth* 1994;41:502-12.
3. Robinson J, Banerjee R, Landzberg M, Thiet MP. Inhaled nitric oxide therapy in pregnancy complicated by pulmonary hypertension. *Am J Obstet Gynecol* 1999;180(4):1045-46.
4. Goodwin T, Gherman R, Hameed A, Elkayam U. Favorable response of Eisenmenger syndrome to inhaled nitric oxide during pregnancy. *Am J Obstet Gynecol* 1999;180(1):64-67.
5. Easterling T, Ralph D, Schmucker B. Pulmonary hypertension in pregnancy: treatment with pulmonary vasodilators. *Obstet Gynecol* 1999;93:494-8.
6. Kiss H, Egarter C, Asseryanis E, Putz D, Kneussl M. Primary pulmonary hypertension in pregnancy: A case report. *Am J Obstet Gynecol* 1995;172:1052-4.

Johnie Walker Murphy Memorial

## Lung Symposium 2000

### UPDATE: Diagnosis & Management of Asthma

Friday  
September 22  
9 am - 3 pm

Ellis Conference Center  
at AHEC South Arkansas  
460 West Oak  
El Dorado, AR

For more information  
call: 870-862-7765

✚ AMERICAN LUNG ASSOCIATION  
of Arkansas

**G o t  
s o m e  
i s s u e s**

**you'd like  
to see  
addressed  
in**

**The Journal?  
call Natalie**

**Gardner at**

**(501) 372-1443**

**or e-mail**

**ngardner@abpg.com.**



There's a simple way  
to determine the value  
of your malpractice insurance.

# Get sued.

We said it was simple. We didn't say it was a lot of fun. But you get what you pay for. And with Medical Protective you're paying for a company that wins 90% of its cases that go to trial with a vast majority closing with no payment. You're paying for coverage that fits your needs and a policy that leaves the final decision to settle in your hands.\*

You're also paying for something else – peace of mind. A peace of mind that was recently strengthened when The Medical Protective Company became a part of Employers Reinsurance Corporation, a GE Capital Services company. This union solidifies our absolute commitment to the protection of doctors like you. If your most valuable asset, your reputation, is on the line, protect yourself with our unparalleled defense strategy. Nearly 60,000 of your colleagues do. For the Medical Protective representative in your area, call (800) 344-1899.

[www.medicalprotective.com](http://www.medicalprotective.com)



***The Medical Protective Company®***

\*Unless prohibited by law.



# PEOPLE+EVENTS

## RETIREMENT

### **Dr. Harry Ward Leaves UAMS Post**

Dr. Harry Ward, chancellor of the University of Arkansas for Medical Sciences for 21 years, announced his retirement, effective Dec. 31.

Dr. Ward, 67, is credited with transforming UAMS into a nationally recognized institution known for its cutting-edge research, including construction of the Arkansas Cancer Research Center, the Jones Eye Institute and the Reynolds Center on Aging. UAMS' multiple myeloma center is considered one of the best in the world, drawing patients from across the world. University Hospital was listed in the top 50 in four categories in the most recent *U.S. News and World Report* hospital rankings.

During his time, Dr. Ward oversaw more than \$200 million in construction projects on the campus. The campus has increased fivefold and has become one of the state's largest employers, with nearly 8,000 employees.

Dr. Ward is an internist with an emphasis on hematology. Although he hasn't been in practice for about 15 years, he still visits patients in University Hospital's intensive-care unit and is still consulted by other physicians on challenging cases.

Dr. I. Dodd Wilson, executive vice chancellor, dean of the College of Medicine and a professor in the department of medicine, will replace Dr. Ward as

chancellor. He will assume the position Oct. 16.

### **Dr. Wallace Retires After 42 Years**

Dr. Oliver Wallace, a family practice physician in Green Forest, recently retired after 42 years in practice.

The 68-year-old physician, who graduated from medical school in 1956, was honored in two receptions held June 18 at Green Forest United Methodist Church and June 30 at his Green Forest Clinic.

An active member of his profession, Dr. Wallace served 12 years on the PRO Board, a medical review board for Medicaid and Medicare, was president of the American Academy of Family Physicians and was a councilor for the Arkansas Medical Society.

During his tenure in Green Forest, Dr. Wallace helped establish a nursing home in Berryville, start a family planning clinic, secure the building for the local health department clinic and start home health services in Carroll County. In addition, Dr. Wallace lent his support to initiating a Meals on Wheels program and transportation services for the elderly.

Dr. Wallace's plans for the future include travel, honing his computer skills, developing a cookbook for men and painting.

## HONORED

### **AMA Names PRA Recipients**

Each month the American Medical Association presents the Physician's Recognition

Award to those who have completed acceptable programs of continuing education.

AMA recipients for April include Dr. Roy D. Coleman of White Hall, Dr. Kenneth P. Collins of Harrison, Dr. Rebecca R. Floyd of Van Buren, Dr. Edward J. Jones of Batesville, Dr. Glen C. Knowles of Bradford, Dr. Albert S. Koenig of Fort Smith, Dr. Elvin L. Norris of Beebe, Dr. Robert L. Prosser of McGehee, Drs. Jonathan M. Cook and Lynda B. Milligan of North Little Rock, Drs. Robert L. Kerr and Kenneth M. Kilgore of Mountain Home and Drs. James Z. Mason and David R. Rozas of Little Rock.

## OBITUARY

### **Fredric J. Sloan, MD**

Dr. Fredric J. Sloan, 77, of Batesville died March 7.

Born in Walker, Iowa, Dr. Sloan was a retired general surgeon.

Dr. Sloan received a bachelor of science degree at Coe College in Cedar Rapids and attended the University of Iowa School of Medicine. He practiced medicine for 30 years in Cedar Rapids and for five years at Sullivan, Ill.

Survivors include four sons, Dr. Fredric J. Sloan II of Eureka Springs, Steve Sloan of Cedar Rapids, Michael Sloan of Batesville and Dr. Luke Sloan of Hood River, Ore.; two daughters, Patricia Perkins of Seattle and Jody Murphy of San Francisco; a brother, Dr. Jim Sloan of Independence, Iowa; the mother of his children, Marilyn Miller of Hot Springs; 12 grandchildren; and three great-grandchildren.

He was preceded in death by his parents and wife, Lynn Hodges Sloan. ■

### **Resolution**

#### **Walter J. Wilkins Jr., MD**

WHEREAS, the members of the Jefferson County Medical Society are deeply saddened by the death of an esteemed member, Walter J. Wilkins, Jr., M.D.; and

WHEREAS, Dr. Wilkins demonstrated his dedication to his profession by many years of membership in this Society, the Jefferson County Medical Society, and as a fellow of the American College of Surgeons; and

WHEREAS, Dr. Wilkins' patriotism was evidenced by his service in the Army Medical Corps from 1945 to 1947, stationed with the occupation troops in Japan and

WHEREAS, Dr. Wilkins utilized his leadership abilities in positions such as Director of Medical Affairs and Chief of Surgery at Jefferson Regional Medical Center, and

WHEREAS, Dr. Wilkins inspired thousands of medical students as an instructor for the University of Arkansas Medical School Department and as an associate clinical surgery professor at the University of Arkansas for Medical Sciences; and by helping develop the baccalaureate nursing program at the University of Arkansas at Pine Bluff and the associate nursing degree program at the University of Arkansas at Monticello.

BE IT THEREFORE RESOLVED:

THAT, this resolution be adopted and placed in the archives of the Society; and

THAT, a copy be sent to Dr. Wilkins' family as an expression of our sincere sorrow; and

THAT, a copy be made available to the *The Journal of the Arkansas Medical Society* for publication.



# ADVERTISERS INDEX

AMS Benefits Inc. ....	Inside back cover
American Lung Association .....	99
Arkansas Financial Group Inc., The .....	102
Arkansas Foundation for Medical Care .....	Inside front cover
Arkansas Managed Care Organization .....	80
Arkansas Department of Human Services .....	78
Central Flying Service .....	85
Employers Healthcare Resources Inc. ....	81
Guest House Inn .....	87
HealthLink of Arkansas .....	95
Helena Regional Medical Center .....	89
Little Rock Medical Association .....	97
Maggio Law Firm .....	91
Medical Protective Co., The .....	100
Metropolitan National Bank .....	89
PhyAmerica Physician Services Inc. ....	87
Riverside Motors .....	75
St. Paul Medical Services .....	93
Smith Capital Management .....	95
Snell Prosthetic & Orthotic Laboratory .....	76
Southwest Capital Management Inc. ....	81
State Volunteer Mutual Insurance Co. ....	Back cover

Special Publications  
Publisher  
*Brigette Williams*

Special Publications  
Editor-in-Chief  
*Natalie Gardner*

Assistant Editor  
*Christy L. Smith*

Sales Manager  
*Stephanie Hopkins*

Account Executive  
*Liz Earlywine*

Director of Design &  
Circulation  
*Virgeen Healey*



**ARKANSAS BUSINESS  
PUBLISHING GROUP**

Chairman and  
Chief Executive Officer  
*Olivia Farrell*  
President and Publisher  
*Jeff Hankins*

Production and Circulation  
Coordinator  
*Jeremy Henderson*

Editorial Art Director  
*Irene Forbes*

Advertising Art Director  
*Matt Stewart*

Advertising Coordinator  
*Kristen Heldenbrand*

Marketing Assistant  
*Mitzi Tiffie*

Database Administrator  
*H.L. Moody*

Advertising Assistant  
*Steven White*

Executive Vice President  
*Sheila Palmer*

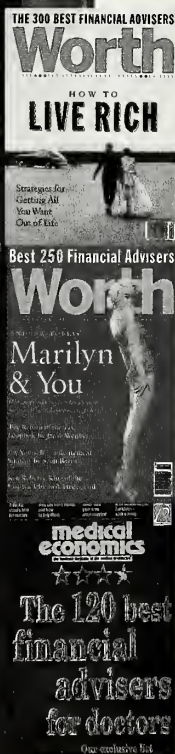
© 2000 Arkansas Business  
Publishing Group  
[www.abpg.com](http://www.abpg.com)

**Two of the best financial  
planners in the nation  
are in Arkansas.**

**They can be found at The Arkansas Financial Group.**

**CINDY CONGER**  
MBA, CPA/PFS, CFP

**RICK ADKINS**  
MBA, CFP, ChFC



Since 1985, we've been helping busy people make smart financial decisions. So next time you're looking for objective answers to life's crucial financial decisions, call The Arkansas Financial Group. You'll be in great company.

Here's what the editors of *Worth* and *Medical Economics* had to say:

**"The Best 250 Financial Advisers, 9/99"**

**"The Best 300 Financial Advisers, 9/98"**

**"The Best 250 Financial Advisers, 10/97"**

**"The 120 Best Financial Advisers for Doctors, 7/27/98"**

**"Fee-only, objective, customized, comprehensive, affordable advice"**

**The Arkansas  
Financial Group, Inc.  
376-9051**

PHOTO: KELLY QUINN/TERRITORIAL RESTORATION



# Arkansas Medical Society Health Benefit Plan...



AMS BENEFITS, INC.

A wholly owned subsidiary of the  
Arkansas Medical Society

P. O. Box 55088

Little Rock, Arkansas 72215-5088

(501) 224-8967

WATS 1-800-542-1058

FAX (501) 224-6489

Ask about our other services including  
Professional Overhead, Disability  
& Life Insurance.

A black and white photograph of a doctor's office. On the left, a white lab coat hangs on a mannequin. In the center, a vintage sewing machine sits on a wooden table. To the right, a wooden chair with a dark seat cushion is visible. The background features a framed picture of a group of people on the wall and a patterned rug on the floor.

*tailor-made for physicians*

The Arkansas Medical Society Health Benefit Program is a health insurance plan designed exclusively for members of the Arkansas Medical Society. Underwritten by American Investors Life Insurance Company. Indemnity and managed care plans available. For information call (501) 224-8967 or 1-800-542-1058.





**A**voiding litigation is always a good idea. In fact, staying out of the courtroom permanently is one of the trickiest, most brilliant procedures you may ever undertake. SVMIC places a unique focus on keeping our policyholders where they belong, at their patient's side and not stuck in some courtroom. We employ a full-time staff of attorneys that are available to all of our policyholders, even before a problem ever arises. Along with an entire battery of unrivaled risk management programs, they can keep the fickle finger of litigation from pointing at you.



For more information, contact Susan Decareaux or Thad DeHart • P.O. Box 1065 Brentwood, TN 37024-1065 • e-mail: [svmic@svmic.com](mailto:svmic@svmic.com) • Web Site: [www.svmic.com](http://www.svmic.com) • 1-800-342-2239 • (615) 377-1999

**We all deserve our day in court, unless of course we can avoid it.**





# THE Journal

OF THE ARKANSAS MEDICAL SOCIETY

Vol. 97 No. 4

October 2000

The  
Good  
Life

ement

With  
Care

Champion

AMA Honors State Senator  
With National Award

\*\*\*\*\*MIXED ADC 64240  
54 P2  
HEALTH SCIENCES LIBRARY  
UNIVERSITY OF MARYLAND  
ACQUISITIONS/SERIALS DEPT.  
601 WEST LOMBARD ST.  
BALTIMORE MD 21201

HS/HSL  
UNIVERSITY OF MARYLAND AT  
BALTIMORE  
STACKS SEP 26 2000

REC'D

NOT IN CIRC.

STACKS



In your job every decision is

CRUCIAL

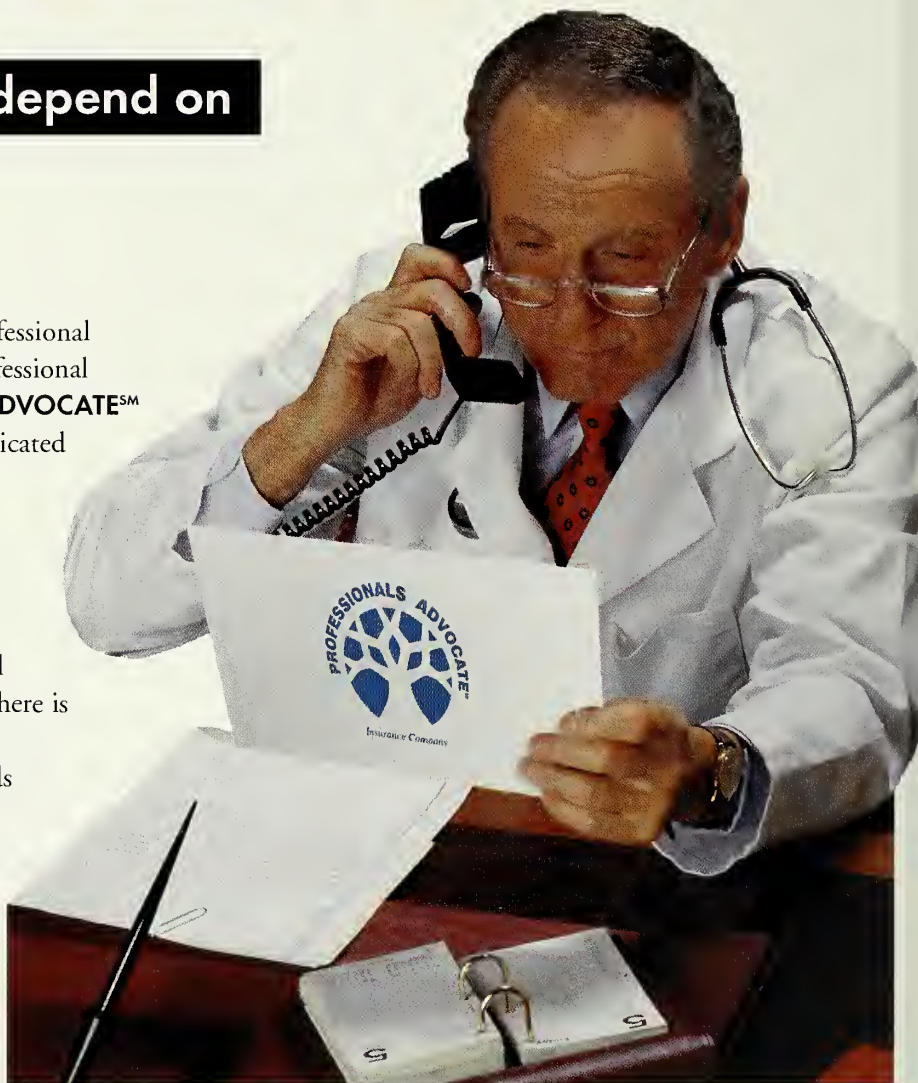
That's why you should depend on

## PROFESSIONALS ADVOCATE<sup>SM</sup>

If you want to make the right choice for your professional liability insurance, start by choosing the right professional liability insurance company. **PROFESSIONALS ADVOCATE<sup>SM</sup>** (**ProAd**) is a physician-owned liability insurer dedicated to the long-term defense of your career.

**ProAd** was founded by one of the oldest and most respected physician-owned and directed liability insurance companies in the country. This legacy gives us a solid foundation of financial resources, stability and experience. And, because there is direct physician involvement in the decisions that affect you, we are sensitive to the special needs of physicians and have a genuine commitment to protecting your reputation and practice.

Let **ProAd** be your advocate. Call today for additional information and a no-obligation quotation from a **ProAd** Agent conveniently located near you.



## The ProAd Advantage

- Quality coverage for all specialties at competitive prices from a financially stable physician-owned insurer.
- Free Tail coverage upon your full retirement with no age requirement, following one full year of continuous claims-made coverage with **ProAd**.
- Absolute Consent to Settle provision.
- New Practitioner discount.
- Full Prior Acts Coverage available.
- Aggressive claims defense policy. Top local attorneys specializing in medical malpractice defense.
- Defendant's reimbursement coverage. All covered attorney fees and defense-related expenses associated with the investigation paid by **ProAd**.
- Prompt and responsive service.
- Knowledgeable local agents selected for their health care expertise.
- MedGuard Defense Coverage with a limit of \$25,000 for defense of administrative or judicial proceedings included at no additional charge.



*Insurance Company*

**Professionals Advocate<sup>SM</sup>**

[www.weinsuredocs.com](http://www.weinsuredocs.com)

Arkansas Agent: Rebsamen Insurance  
1500 Riverfront Drive, P.O. Box 3198  
Little Rock, AK 72203  
501-661-4800 • 501-666-9592 Fax

# Need

to

# Brag?

Let your peers & colleagues know:

Top Flight Hospital Services,

New Hires & Associates,

Promotions, Honors & Awards

**THE**  
**Journal**  
**OF THE ARKANSAS MEDICAL SOCIETY**

For Advertising Information

Contact Stephanie Hopkins

501-372-2816 ext. 293.



There's a simple way  
to determine the value  
of your malpractice insurance.

# Get sued.

We said it was simple. We didn't say it was a lot of fun. But you get what you pay for. And with Medical Protective you're paying for a company that wins 90% of its cases that go to trial with a vast majority closing with no payment. You're paying for coverage that fits your needs and a policy that leaves the final decision to settle in your hands.\*

You're also paying for something else — peace of mind. A peace of mind that was recently strengthened when The Medical Protective Company became a part of Employers Reinsurance Corporation, a GE Capital Services company. This union solidifies our absolute commitment to the protection of doctors like you. If your most valuable asset, your reputation, is on the line, protect yourself with our unparalleled defense strategy. Nearly 60,000 of your colleagues do. For the Medical Protective representative in your area, call (800) 344-1899.

[www.medicalprotective.com](http://www.medicalprotective.com)



***The Medical Protective Company***



# THE Journal

OF THE ARKANSAS MEDICAL SOCIETY

Winner of the ASAE Excellence in Communications Award

## CONTENTS

### FEATURES

#### 115 The Big Easy

*Arkansas physicians are retiring early in the face of increased managed care headaches and long hours.*

#### 120 Advocating for Breast Cancer Awareness

*Dr. Michael Cross of Fayetteville is a champion of breast cancer research and awareness. As a member of the state's Oversight Committee on Breast Cancer Research, Dr. Cross fights to give money to those making headway in finding a cure.*

#### 123 State Senator Honored

*State Sen. Jay Bradford was named as the American Medical Association's winner of the Nathan Davis Award, which recognizes those in government who are fighting for public health and the medical field.*



*An increasing number of Arkansas physicians are leaving their practices to pursue other interests.*

— page 115



*Dr. Thomas A. Formby is UAMS' Distinguished Alumnus for 2000.*

— page 135

### DEPARTMENTS

#### 111 Commentary

*William E. Ackerman, III, MD*

#### 113 What We've Done

*For You Lately*

#### 124 Loss Prevention

#### 125 Radiology Report

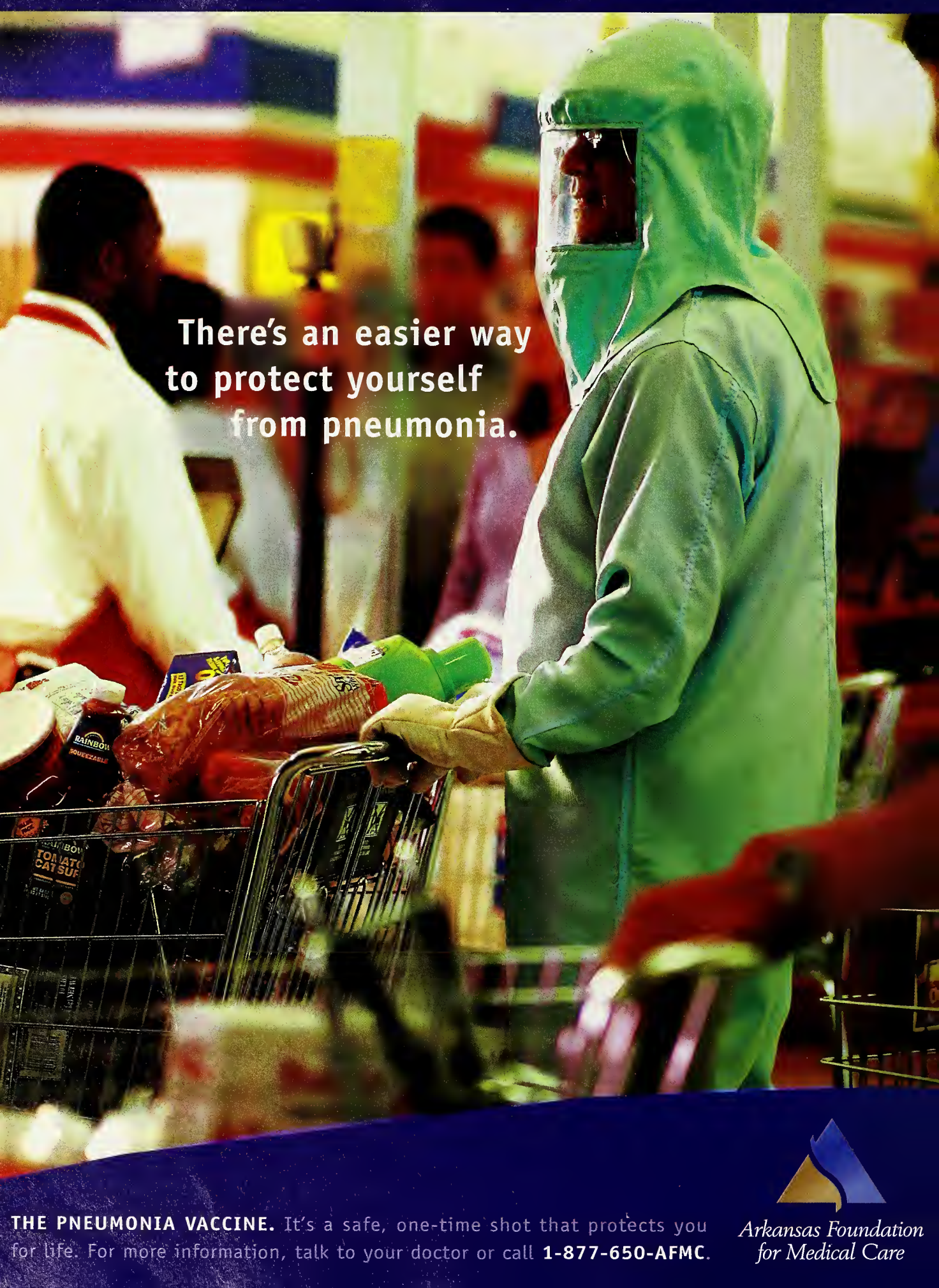
#### 128 Cardiology Report

#### 135 People + Events

#### 137 Arkansas Retreats

#### 138 Index to Advertisers



A person wearing a full-body white protective suit, including a hood and a clear face shield, is pushing a shopping cart in a grocery store. The cart is filled with various items, including a large bag of red tomatoes, a green bottle, and a box of 'Rainbow Soufflé'. In the background, other people are visible, including a man in a white shirt and red apron. The scene is brightly lit, typical of a grocery store.

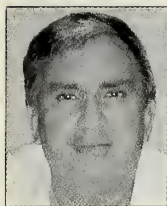
There's an easier way  
to protect yourself  
from pneumonia.

**THE PNEUMONIA VACCINE.** It's a safe, one-time shot that protects you for life. For more information, talk to your doctor or call **1-877-650-AFMC.**



*Arkansas Foundation  
for Medical Care*





# Internet Information is a Double-edged Sword

WILLIAM E. ACKERMAN, III, MD

**B**ecause medical information can now be obtained from Internet sources, physicians are occasionally caught off guard by those patients who have information about their diseases that their physicians know nothing about. On the other hand, physicians can spend considerable time with patients countering false opinions and medical claims obtained from the Internet.

The Internet is a large system of connections between a vast number of computers. One connects to the Internet by an Internet Service Provider (i.e., America Online) using a telephone modem. Once connected to the Internet, a web site must be contacted. A web site (i.e., [www.WebMD.com](http://www.WebMD.com)) is a collection of files on a web server computer that is connected to the Internet and sends information to other computers on the Internet by special communication methods.

A web browser (i.e., Netscape) is a computer program that enables one to view information obtained from the Internet that is written in a standard format called Hypertext Markup Language (HTML). The World Wide Web (W/W/W) is a subsection of the Internet. The World Wide Web is the most popular section of the Internet and can present information in a multimedia format. A web site is found by using software referred to as a search engine (i.e., Yahoo). A search engine performs specialized searches for information found on various web sites and places the information in a well-indexed directory.

Because of the Internet and various web sites, medical reports, medical news and many medical journals are now accessible to anyone who has access to a computer and modem. Many electronic health web sites offer not only basic general health information but also highly technical information (The National Institute of Health's National Library of Medicine).

Today there is a great demand from patients for

medical literature. A problem faced by many physicians is the reliability of the data available. Many patients come to a physician's office with a multitude of pages printed from various web sites. Many patients do not realize that treatment suggestions presented on some web sites are by no means uniformly effective. There is a tendency for some individuals who have little faith in traditional medicine to rely on web sites, many of which offer treatment suggestions that offer little or no scientific basis.

Patients do not always understand the ambiguity in the medical literature. A patient may expect a definitive answer to a particular disease. The American Medical Association is helping physicians set up customized web sites that will enable patients to access credible medical literature, ranging in format from a junior high school level to a more sophisticated level.

Even with this information a double-edged sword still exists because the therapeutic information extracted from the physician's web site may not be applicable to a particular patient. Patients must be aware that the art of medicine involves a physician's awareness of both the pathophysiological and psychopathological problems encountered. A physician, unlike a web site, has access to a range of medical, physical and psychological therapies for many disease entities based upon the results of a

patient's history, physical examination and laboratory and imaging studies. The practice of medicine is an art and is much more than the application of scientific knowledge to a particular pathologic occurrence. The Internet is useful when it helps patients understand their diseases but becomes a nuisance when they use it to dictate their care. ■

*Dr. Ackerman is an anesthesiologist/pain management specialist in Little Rock and a member of The Journal of the Arkansas Medical Society editorial board.*



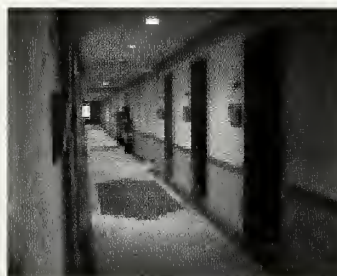
**"The Internet is  
like a tidal wave  
which will wash  
over the computer  
industry and many  
others, drowning  
those who don't  
learn to swim in  
its waves."**

**— Bill Gates, founder  
of Microsoft**



# EXCELLENT OPPORTUNITY

- ★ Medical Space  
St. Vincent Campus
- ★ Available immediately
- ★ Entire 5th Floor
- ★ For sale at \$50  
per gross square foot
- ★ Convenient parking



*For information, please call:*  
Todd Hart or Hank Kelley at  
**501-375-3200**



**FLAKE & KELLEY**  
MANAGEMENT

TCBY Tower, Suite 300, Little Rock, Arkansas 72201  
501-375-3200 Telefax 501-374-9537  
[www.flake-kelley.com](http://www.flake-kelley.com)

COMMUNICATIONS COORDINATOR  
Judy Hicks

EXECUTIVE VICE PRESIDENT  
Kenneth LaMastus, CAE

ASSISTANT EXECUTIVE VICE PRESIDENT  
David Wroten

## EDITORIAL BOARD

Jerry Byrum, MD	Pediatrics
Joseph M. Beck, II, MD	Oncology
Lee Abel, MD	Internal Medicine
Samuel Landrum, MD	Surgery
Jerry Kendall, MD	Family Practice
William Ackerman, MD	Anesthesiology

EDITOR EMERITUS  
Alfred Kahn Jr., MD

## ARKANSAS MEDICAL SOCIETY 2000-2001 OFFICERS

Gerald A. Stolz, Jr., MD, Russellville  
*President*

Joe Stallings, MD, Jonesboro  
*President-elect*

Paul A. Wallick, MD, Monticello  
*Vice President*

Lloyd G. Langston, MD, Pine Bluff  
*Immediate Past President*

Carlton L. Chambers, III, MD, Harrison/Little Rock  
*Secretary*

Dwight M. Williams, MD, Paragould  
*Treasurer*

Anna Redman, MD, Pine Bluff  
*Speaker, House of Delegates*

Kevin Beavers, MD, Russellville  
*Vice Speaker, House of Delegates*

Joseph M. Beck, II, MD, Little Rock  
*Chairman of the Council*

Established 1890. Owned and edited by the Arkansas Medical Society and published under the direction of the Council.

Advertising Information: Contact Stephanie Hopkins, P.O. Box 3686, Little Rock, AR 72203; (501) 372-2816.

Postmaster: Send address changes to: *The Journal of the Arkansas Medical Society*, P. O. Box 55088, Little Rock, Arkansas 72215-5088.

Subscription rate: \$30.00 annually for domestic; \$40.00, foreign. Single issue \$3.00.

*The Journal of the Arkansas Medical Society* (ISSN 0004-1858) is published monthly by the Arkansas Medical Society, #10 Corporate Hill Drive, Suite 300, Little Rock, Arkansas 72205. Printed by The Ovid Bell Press, Inc., Fulton, Missouri 65251. Periodicals postage is paid at Little Rock, Arkansas, and at additional mailing offices.

Articles and advertisements published in *The Journal* are for the interest of its readers and do not represent the official position or endorsement of *The Journal* or the Arkansas Medical Society. *The Journal* reserves the right to make the final decision on all content and advertisements.

Copyright 2000 by the Arkansas Medical Society.



## Paperwork Will Decrease With New HIPPA Regulations

By DAVID WROTEN

**Y**ou probably haven't heard much about HIPPA, but you will. The Health Insurance Portability and Accountability Act of 1996 is going to have a profound impact over the next two or three years. You need to be sure HIPPA is on your radar screen and begin now to understand its impact on your practice.

Title I, which has been in effect for the last two years, guarantees health insurance access, portability and renewal. Title II, scheduled to be implemented during the next two years, is aimed at simplifying and advancing e-commerce in the health care system and guaranteeing security and privacy of health information.

Title II requires Health and Human Services to adopt national standards for electronic administrative and financial health care transactions. There are hundreds of electronic claim submission formats currently in use. These standards will force all health carriers, clearinghouses and software makers to utilize one format. The costs associated with these changes are estimated to make Y2K look like pocket change.

Providers who file electronic claims can either alter their existing systems to comply with the standards or contract with a clearinghouse that will receive the claim as they do now, then reformat the claim to meet the standard.

Once implemented, there will be only one electronic format for claim transactions and other transactions that are usually handled by paper. These include claim attachments (i.e. progress notes, medical records, etc.), premium payments, referral and authorization forms and claims payment and remittance advices. By mid-2002, all health carriers must be able to accept these administrative transactions electronically.

Other provisions included in these standards require adoption of standard code sets such as ICD-9 and CPT-4 for coding of diagnosis and services, the elimination of local codes such as those used by Medicaid programs and unique ID numbers for individuals, employers, health plans and providers.

The regulations for electronic transaction standards have recently been finalized. Carriers have approximately 24 months to change their systems to comply with the new standards, at which time they will be required to have the ability to accept all of the mentioned transactions electronically in the standard formats. This does not affect the ability of providers to produce and submit paper claims; they may continue to do so.

Two other provisions in Title II relate to security and privacy of medical information. These are still in the draft or proposed rule stages but are expected to be implemented over the next two years, as well. HIPPA mandates the establishment of security policies by any one who maintains or transmits health information. There is a separate but related provision dealing with privacy of medical information. Both of these provisions will impact physicians and will require the adoption of new policies and procedures for how medical records are handled.

The pessimist would say "here comes another round of government overregulation that is likely to force me into early retirement." The optimist would say "here is an opportunity to go paperless and take advantage of technology to improve my bottom line by reducing my overhead and the amount of time spent on paperwork, while at the same time providing more assurances to my patients that their medical information is safe and will be kept confidential." Take your choice.

What should you do now? Realize that this is not happening overnight. Take the time to educate yourself and your staff on what HIPPA is and is not. Numerous web sites contain HIPPA information. The AMS and others will offer HIPPA educational programs in the near future. Take the first step by talking with your software vendor or clearinghouse about the transaction standards and their plan for compliance. If you have custom software, talk to your programmer. Expect more information from the AMS as regulations become final. ■

## PHYSICIANS

**Air Force Healthcare.  
Good Pay.  
Professional Respect.**

### Why Do You Think We Say "Aim High"?

Experience the best of everything.  
Best facilities. Best benefits.  
Outstanding opportunities for  
travel, 30 days vacation with pay,  
training and advancement.

**For an information packet call  
1-800-423-USAF**

or visit [www.airforce.com](http://www.airforce.com)  
You'll see why we say, "Aim High."



## ARCHITECTURE

FOR

YOUR

MEDICAL

NEEDS

**William Henry Asti, AIA**  
architects, economists,  
development consultants

1 800 764-ASTI



*We're known for our abilities...*

# Flexibility.

We know you have a choice about your healthcare plan. That's why we offer the flexibility you want so you can get the care you deserve. We are Arkansas people working to take care of your health — we're Arkansas Managed Care Organization (AMCO).

# Accountability.

Our statewide PPO network offers community care through:

- More than 3,800 physicians and hundreds of other healthcare professionals;
- Services in over 100 hospitals; and,
- An excellent staff representing your best interests.

# Stability.

AMCO is a recognized leader in managed healthcare in Arkansas, not only because of our size, but also for our high degree of accountability, outstanding customer service and stability.



Call us today at  
**1-800-278-8470** or  
**501-225-8470.**

#10 Corporate Hill Drive, Suite 200  
Little Rock, Arkansas 72205  
[www.amcoppo.com](http://www.amcoppo.com)

*Serving employers and their greatest  
asset with quality managed care.*

**Putting the *Care* back in Managed HealthCare**



# The Big Easy

By Christy L. Smith

## Arkansas Physicians are Retiring Early in the Face of More Paperwork and Longer Work Days



Photo Kirk Jordan

*Dr. Ronald Hughes, 50, retired from practice this summer to spend more time with his family, including children, Drew, 21, and Lindsay, 18.*

**F**or 20 years, Dr. Ronald Hughes rarely saw daylight. The Little Rock nephrologist found himself caught up in a whirlwind of hospital rounds and clinic appointments that began every weekday at 6 a.m. and did not end until 12 — sometimes 13 or 14 — hours later.

Call duty every fourth night and every other weekend left even less time for Dr. Hughes to spend with his family, a straw that finally broke this camel's back about a year ago.

"You start figuring how many hours you put into the job, and basically at 20 years I've worked as many hours as most people do in 30 or 35 years," he said.

This summer, the 50-year-old physician retired from private practice. Dr. Hughes now works part-time as medical director of Research Solutions, a pharmaceuticals testing company in Little Rock, and he

**"You start figuring how many hours you put into the job, and basically at 20 years I've worked as many hours as most people do in 30 or 35 years."**

**— Dr. Ronald Hughes**



serves as a quality assurance consultant to a Dallas-based dialysis company.

"I debated for a long time trying to work out a deal where I could keep practicing and not take call, but I'm not sure it's fair to your partners. It forces your partners to work harder and ultimately places a strain on the working relationship," Dr. Hughes said.

### Winding Down

Frustrated with the time commitments required by their careers and the hassles of managed care, an increasing number of physicians are retiring before age 60, according to the American Medical Association.

The AMA recently conducted a telephone survey of 300 physicians in their 50s and found that 38% of them are planning to retire in the next three years. Another 16% will reduce their workloads, and 10% said they will stop seeing patients in order to pursue another career.

Arkansas also has been swept up by that trend, said Lynn Zeno, the Arkansas Medical Society's director of governmental affairs.

"When I started with the medical society [11 years ago], many [of the member physicians] were just blossoming in their mid-60s. At 65 years old, they were still outstanding surgeons, outstanding providers and still had a lot of bounce in their step," Zeno said.

But ever-increasing regulation by insurance companies and the government is forcing many physicians to rethink their career paths, he said.

"They are spending far too little time with patients and far too much time with the administrative part, and that's not why they went to medical school. Many are retiring for all the wrong reasons," Zeno said.

And the booming economy has given physicians the vehicle they need to pursue other interests, he added.

"Doctors were fortunate and wise in their investments. The stock market has been very kind to all investors, so it's enabled [doctors] to build nest eggs so they just don't have to hassle with the practice of medicine anymore," he said.

### Avoiding Managed Care

Although it played a minor role in his decision to change careers, Dr. Hughes acknowledged that managed care is a problem for physicians.

"They make all the rules; they tell you how [medicine is] going to be practiced, and there's an ever-increasing

burden of paperwork, meetings you have to go to, hoops you have to jump through to get things done," he said.

However, Dr. Hughes said he thinks physicians are retiring early because they have so many other career choices at their fingertips.

"There are lots and lots of opportunities out there now for administrative positions in medicine. There are more and more people hiring doctors. A medical degree is a marketable commodity," he said.

That was the case for 58-year-old Dr. Jack Blackshear, a Little Rock gastroenterologist. In 1993, after 17 years in private practice, Dr. Blackshear went to work as the medical director of an insurance company.

"I was in the belly of the beast. I [felt] I could be an interface between physicians and patients who had grievances against the companies for payment," he said.

But Dr. Blackshear found himself caught between his ethical duty to support "quality patient care" and his employers' denial of legitimate claims. As medical director, he reviewed denials and overturned more than half of

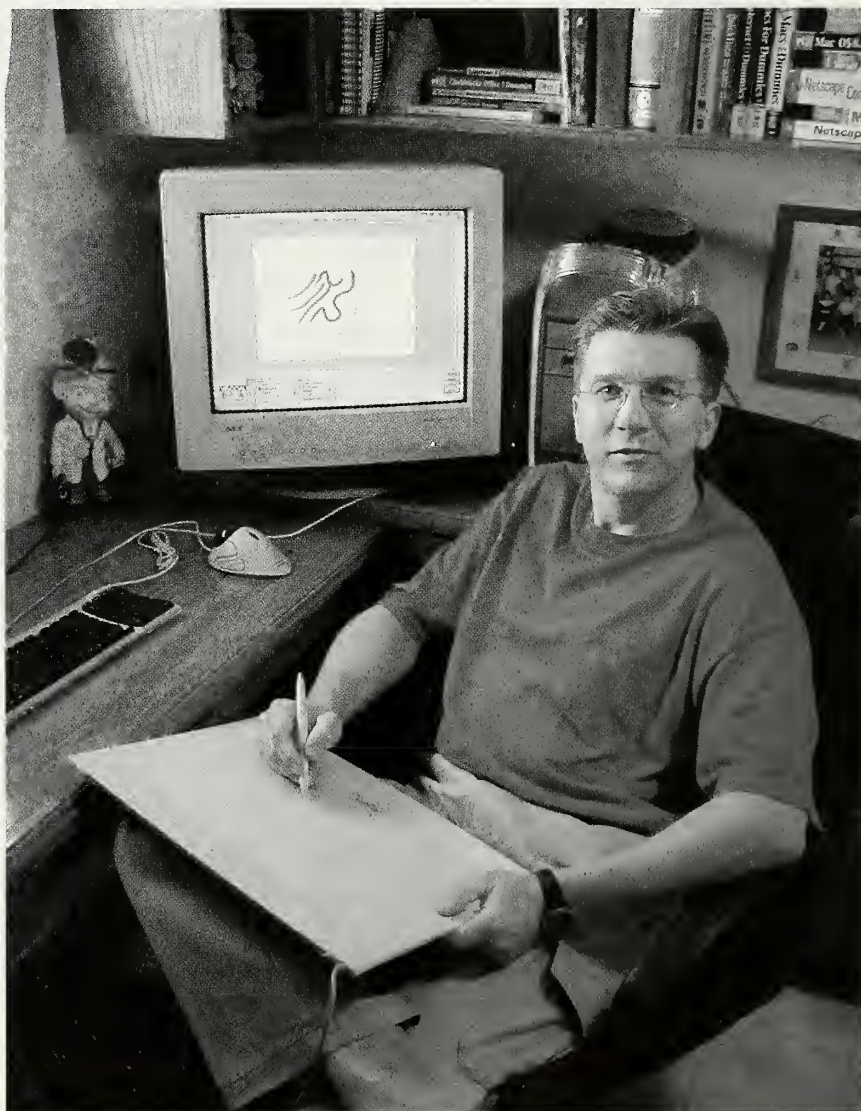


Photo: Kirk Jordan

*Frustration with the workers' compensation system forced 48-year-old Dr. Dennis Luter into early retirement. He is now co-owner of a drug testing company.*

them, only to have his decisions reversed later on, he said.

"Their bottom line was making a profit, and my bottom line was geared more toward quality medicine. I was unwilling to turn my back on my colleagues and what I knew was really good medicine for the sake of maintaining the viability of a company," said Dr. Blackshear, who determined in 1996 that he is "better-suited" as a physician.

Dr. Blackshear now works three days a week at John L. McClellan Memorial Veterans Hospital in Little Rock, performing five-six endoscopic procedures each day. In his spare time, Dr. Blackshear plays golf, sings, practices his clarinet, escorts medical students on mission trips and cares for his parents. He said that managed care as well as the idea of leading a non-scheduled life is drawing physicians out of practice.

"When I was in medical school, we all expected to be slaves to our calling. Young people coming into medicine now want to be better rounded in life, [and] the paperwork has just become overpowering. I think more and more physicians will retire as the [managed care] pressures grow," he said.

### Company Man

Physicians of every specialty are becoming increasingly frustrated at losing control over the patient care process, Zeno agreed.

"Quite frankly, the medical decision-making is not in the hands of the doctor and patient anymore," Zeno said.

Frustration led Dr. Dennis Luter to leave his practice last year. The 48-year-old orthopedic surgeon from Jonesboro said he began seeking other career opportunities five years ago because the health care system presents far too many hurdles for physicians to overcome.

"I loved medicine, and I loved orthopedics particularly. But there are some things that no longer make it tenable for many of us to keep practicing, and managed care is only one portion of the system," he said.

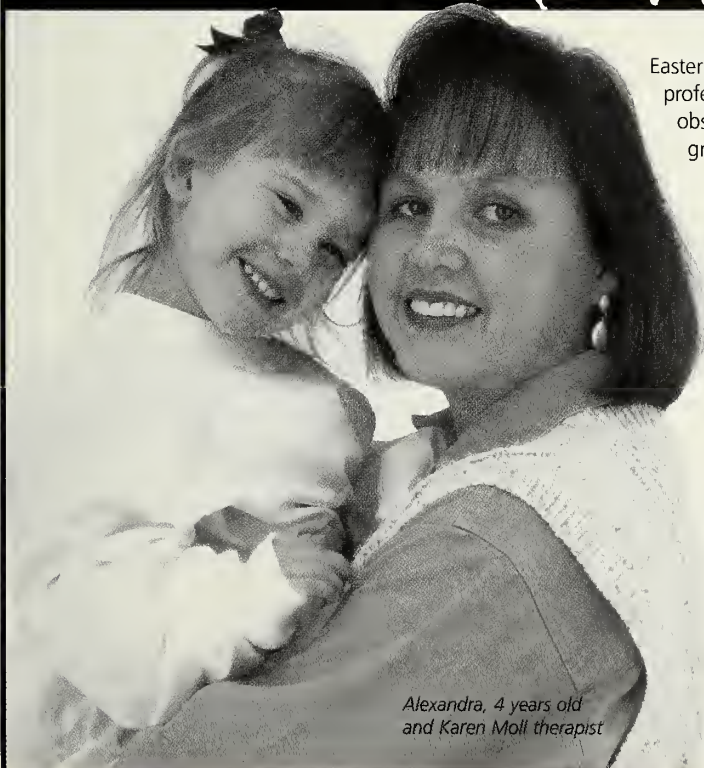
Dr. Luter said he was constantly being pulled in different directions by hospitals, insurance companies, lawyers, patients and their employers because orthopedics involves so many workers' compensation cases.

"My role became not so much of a healer. My role became more of a judge, a secretary, a mediator. I was spending too much time educating insurance companies about the nature of disease and treatment," he said.

Dr. Luter now co-owns a drug testing company, and he spends much of his free time gardening, reading books about art and traveling with his wife. But best of all, Dr. Luter said, he rarely experiences a sleepless night.

"That's something I hadn't known in 20 years," Dr. Luter said.

# The Staff of Life



*Alexandra, 4 years old  
and Karen Moll therapist*

Easter Seals is an astonishing range of services, programs and professional caregivers whose common goal – and uncommon obsession – is helping children and adults with disabilities gain greater independence.

With more than 35 years of experience in the evaluation and treatment of children with disabilities, Easter Seals' evaluation team is one of the most experienced in the state. We also provide hospital to home monitoring services for infants, inpatient and outpatient pediatric therapies and preschool services. If we can help a child you know, call our **Outpatient Referral Line at 1.877.533.3600.**



*Creating solutions, changing lives.*

3920 Woodland Heights Road  
Little Rock, AR 72212-2495  
501.227.3600 • [www.arkeasterseals.org](http://www.arkeasterseals.org)



He predicts that physicians — many in their 40s — will continue to retire as long as health care funding and reimbursement decrease and paperwork detracts from patient care.

"The majority of the doctors I know [in the

With an aging population, there's a great need for that specialty," Zeno said.

In addition, this exodus of private practice physicians could create a working atmosphere more to the physicians' liking, but not necessarily geared to the patients' needs, he said.

**"We are seeing [a shortage in some specialties] right now. Statewide there is a real shortage of pulmonologists. With an aging population, there's a great need for that specialty." — Lynn Zeno, AMS**

Jonesboro] area are looking at quitting. Most of my friends are trying to get into something else. But what's really disappointing is that I felt like I was at the peak of my skills [when he retired]. I think that many others who are trying to quit have skills, and they would be willing to work for a whole lot less money if you could get rid of the headaches and the hassles," he said.

If the trend for early physician retirement continues, then the nation may experience a shortage of specialists and an influx of younger physicians who will impact the business of medicine, Zeno said.

"We are seeing [a shortage in some specialties] right now. Statewide there is a real shortage of pulmonologists.

"It's much harder today to start a private practice because practice costs continue to increase, yet reimbursement from insurance carriers and government programs continue to decrease. So, many of today's medical school graduates are [practicing] as employees of a corporation — either a hospital or some other entity," Zeno explained.

That incorporation of medicine removes the profit motive and encourages physicians to view themselves as 8-to-5 employees, he said.

"There's not quite the [profit] incentive to see 60 patients a day and to work from 6 in the morning to 6 or 7 at night," Zeno said.

## Upcoming AMS Meetings

### Collecting with Class and Patient Satisfaction

Tuesday, Sept. 26  
*Holiday Inn Select*  
201 S. Shackleford, Little Rock

9 a.m. - noon  
**Increase Cash Flow - Decrease Headaches**

This seminar is designed for physicians and medical office staff who want to increase cash flow while maintaining strong patient relations.

1:30-4:30 p.m.  
**Improving Patient & Professional Relations**

Quality healthcare is not the only thing that patients consider when choosing a physician. They want quality service in every other respect as well.

**Registration Fees:**  
\$150 per seminar or \$260 all day.  
Lunch provided for participants attending all day.  
Pre-registration is required.

No refunds for cancellations received after Sept. 15.)

### AMS 2000 Fall Meeting

*Embassy Suites*  
11301 Financial Centre Parkway,  
Little Rock

**Saturday, Oct. 28**

6 p.m. Early Bird Reception  
7 p.m. Dinner on your own

**Sunday, Oct. 29**

8 a.m. Tentative Committee Meetings  
9:30 a.m. Council Meeting

**All AMS Members:**

11:30 a.m. Lunch Program: Guide to Using the Grassroots Action Center Internet Link  
1 p.m. Politics, Power & You  
*Michael E. Dunn*  
3 p.m. Break  
3:15 p.m. House of Delegates  
*Lynn Zeno - Legislative Agenda*

### CLIA/OSHA and Your Medical Practice

Wednesday, Nov. 1  
*Holiday Inn Select*  
201 S. Shackleford, Little Rock

The Clinical Laboratory Improvement Amendments of 1988 (CLIA) regulate all testing performed to ensure quality and compliance with the established procedures and policies.

The Occupational Safety and Health Administration (OSHA) requires that all employers provide a safe and healthful place of employment.

**Registration Fees:**  
\$155 for members and staff and \$255 for non-members.

Watch your mail for registration materials or call the AMS office at 501-224-8967.

But the health care system is bound to correct itself, restoring control of patient care to the physician, leveling out the rate at which physicians are reimbursed for their services and bestowing more accountability upon the patient, Zeno said.

"In the late '80s, early '90s, health care costs were out of control. In an effort to correct that, the pendulum has swung too far in the other direction. You would hope that at some point in time the pendulum would come back to the middle," he said.

### Taking Control

Drs. Luter, Blackshear and Hughes agree the system will inevitably change, but they have different ideas about the time frame.

"I think things are going to get worse before they get better, and I just didn't want to be in that time when things get worse," Dr. Luter said.

Dr. Blackshear said the changes will not come any time soon, and they will initially take effect only in small pockets across the nation.

"It can't always be this way. An atmosphere of chaos and change is where innovations come from. I strongly believe that it's going to be a very slow process that won't happen nationwide, but as we see the mergers of these managed care companies. I think [the government] might designate a particular company to take the lead

and then give it support legislatively [to oversee a single payer system]," he said.

In addition, patients will have to accept more responsibility for their health care decisions, if the changes are to be lasting, Zeno and Dr. Blackshear said.

"What's driving the cost of health care is overutilization. In other words, 10 years ago if Johnny had a sore throat, [the parent] picked up some cough medicine or throat spray. Going to the doctor was the last resort. Now with minimum co-payments and first dollar coverage by insurance companies, little Johnny goes to the doctor. With a \$5 or \$10 co-pay, there's no disincentive for the patient not to overutilize health care services," Zeno said.

Dr. Blackshear said he believes the concept of managed care is a difficult one for patients to grasp.

"I believe in a health care system that allows patients to spend within their means. They can't pay \$10 a month and expect to have \$1,000 in medical care as a result. Some expectations that people have are just outlandish," he said.

Once all these factors have come together to create a health care system that allows physicians to concentrate on patient care rather than paperwork, physicians who retired early may return to practice, Zeno said.

"They all still have that desire to take care of patients. That's why they got into medicine in the first place," he said. ■

## Collect Bad Debt

- Cheaper
- Faster
- In compliance with the Law

### Collection Agency



## MAGGIO LAW FIRM

*your collection law firm*

2843 Prince Street., Conway, AR 72033 501-327-4340  
303 N. Spruce Street, Searcy, AR 72143 501-279-2769  
[www.ebaddebt.com](http://www.ebaddebt.com)

If you've always used a collection agency. . . WHY?

Cut out the middle man by retaining the Mike Maggio Law Firm.

Save time. Save money.  
Be in compliance with the law.

Have you always used a collection agency because "that's the way you've always done it?"

*Try a new way. . . tip the scales in your favor, call Mike Maggio today.*



# Meet Our Members

## Michael J. Cross, MD

BY BECCA GARDNER

Doctors often have to answer tough questions. But for Dr. Michael Cross everyday is often full of frightened patients asking hard-to-answer questions.

Many are terrified when they ask, "Am I going to die? Will I lose my breast? What is surgery like? Does chemotherapy hurt? Will I lose my hair?"

As a surgical oncologist with his own practice in Fayetteville, Dr. Cross often takes the extra time to reassure patients and help them and their families come to grips with their diagnoses. The 42-year-old doctor sees about 250 patients each month and performs about 500 surgeries every year, from implant removal to breast biopsy.

A typical day at Dr.

Cross' office could include visits from eight-nine patients whose ages range from the early 20s to late 80s.

"My youngest cancer patient was 26 when [diagnosed]," Dr. Cross said.

Dr. Cross often reviews slides and informs patients of their diagnoses over the weekend so they can discuss treatment plans as soon as possible.

"It's me, face-to-face; it's me answering all their questions," he said. "I give them a chance to ask me as many questions as they need to ask in order to resolve what problem they're having. And I have a really great support staff who make up all the appointments for [patients]."

While the staff schedules the needed X-rays, blood tests and visits to plastic surgeons and radiation oncologists for patients, Dr. Cross handles patients' personal concerns.

### Cutting-Edge Techniques

While Dr. Cross discusses several treatment options with his patients, one of his specialties is performing sentinel node biopsy.

"What we offer is breast conservation, most of the time," Dr. Cross said.

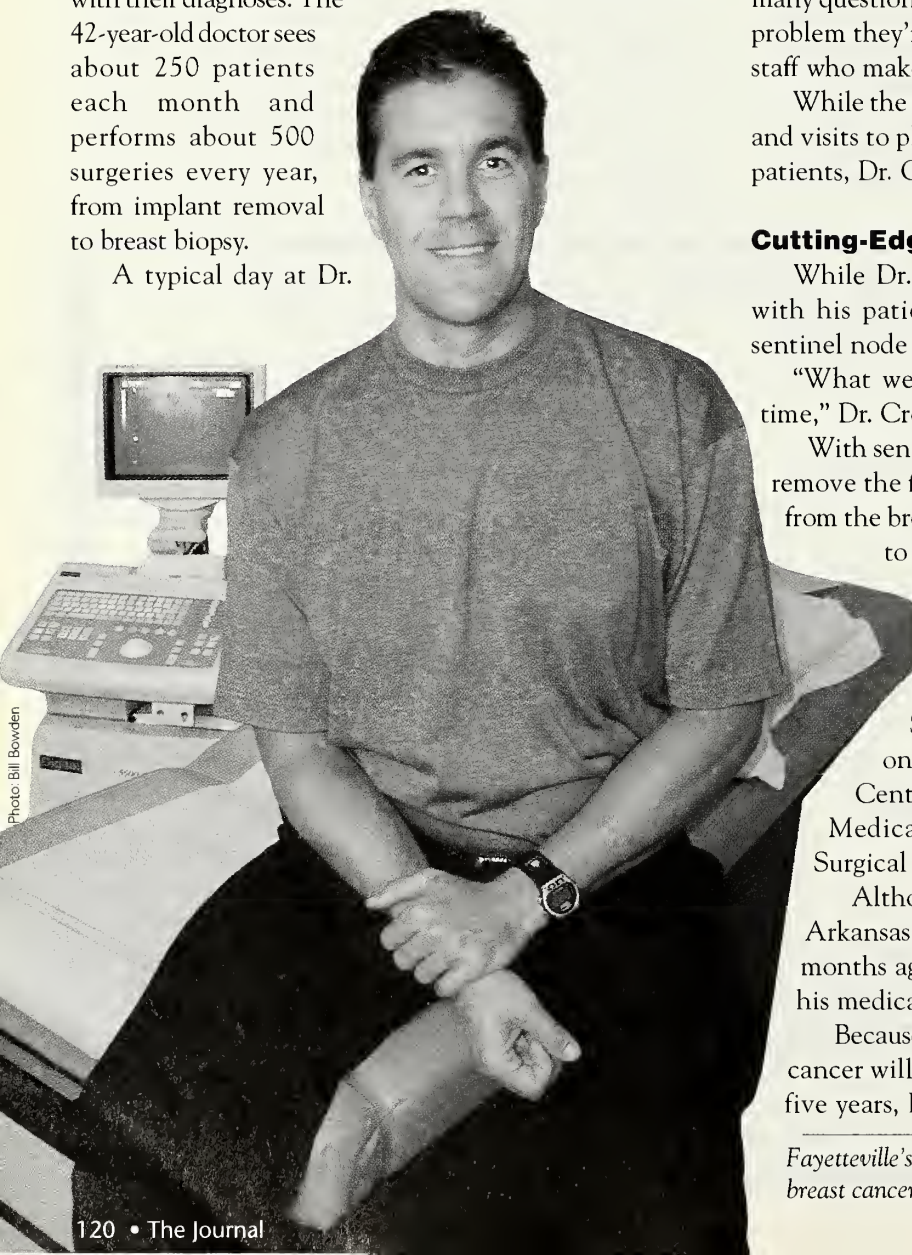
With sentinel node biopsy, a surgeon can identify and remove the first draining lymph node, or sentinel node, from the breast area. The status of the node is then used to assess the health of the remaining nodes.

Dr. Cross has been performing the relatively new surgery for two years and recently co-wrote and presented a paper on sentinel node biopsy — along with Dr. Suzanne Klimberg, director of women's oncology at the Arkansas Cancer Research Center, part of the University of Arkansas for Medical Sciences system — for the Southwest Surgical Congress in Colorado Springs, Colo.

Although most of Dr. Cross' patients come from Arkansas and surrounding states, he was visited two months ago by a 41-year-old Kuwaiti woman seeking his medical expertise for her follow-up care.

Because those patients who will be rediagnosed with cancer will be more likely to be diagnosed within two-five years, Dr. Cross stresses the importance of follow-

*Fayetteville's Dr. Michael Cross is a state advocate for breast cancer awareness and research.*





up care with a physician.

"This happens so much — when a woman comes in, her mammograms are normal, and she still has breast cancer," he said. "And so I let them understand: a normal mammogram does not imply that you do not have breast cancer."

### Funding Research

As a champion of breast cancer awareness, Dr. Cross was reappointed by Gov. Mike Huckabee to the Oversight Committee on Breast Cancer Research in January. The committee, comprised of about 10 steady and rotating members, decides how \$4 million of state money will be spent for breast cancer research and treatment. Of the \$4 million, \$800,000 is spent on research.

Dr. Cross said he is interested in making sure the money goes to "people with a national reputation for breast cancer research, so they'll go on to develop bigger programs. Our

goal is for Arkansas to be a leader in breast cancer research."

Always the advocate, Dr. Cross will help host Breast Cancer Symposium 2000 and will speak to residents of Northwest Arkansas about new breast cancer treatments, all in celebration of Breast Cancer Awareness Month in October.

In addition to the governor's committee, Dr. Cross served on the grants committee of the Ozark Chapter for the Susan G. Komen Foundation and serves on the Internal Review Board for the Washington Regional Medical Center in Fayetteville. With his busy schedule, he depends on the Arkansas Medical Society to keep him informed about issues affecting the practice of medicine.

When he's not working to increase breast cancer awareness and funding, Dr. Cross is an avid cyclist, traveling 23-25 miles at a time. The drive to stay fit partly comes from his

stint on the Arkansas Razorback football team, where he played with Razorback head football coach Houston Nutt under the coaching arm of Frank Broyles and Lou Holtz.

After receiving his bachelor's degree in zoology from the University of Arkansas in 1981, Dr. Cross worked at the Cooper Clinic in Dallas for a year before earning his medical degree from the University of Nebraska College of Medicine in 1987.

He completed a general surgery internship and residency at Scott & White Memorial Hospital in Temple, Texas, in 1992 and a fellowship in surgical oncology of the breast at Baylor University Medical Center in Dallas in 1993.

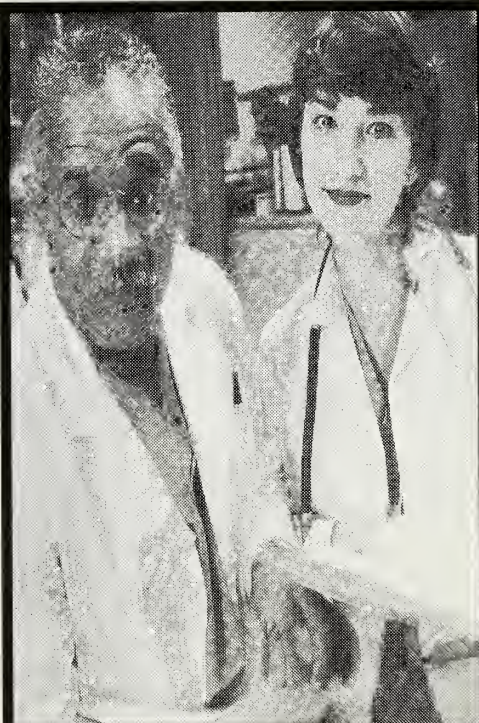
When he's not kayaking or cycling, Dr. Cross enjoys traveling and spending time with his two daughters, Sunni, 10, and Summer, 7. The three recently took a camping trip to the Grand Canyon. ■

## HEALTHY WEALTHY & WISE.

*Financial  
strategies  
specifically for  
physicians.*



At Hutchinson/Ifrah,  
we understand the issues  
that put a physician's practice  
and personal assets at risk.  
But our idea of being healthy,  
wealthy and wise is more than  
simply saving on taxes and  
protecting your assets,  
it's about maximizing your  
investment potential and  
planning for a tax-free  
retirement. Give us a call at  
501/223-9190 and let us show  
you how we can help physicians  
achieve a healthy bottom line.



**Hutchinson/Ifrah  
Financial Services, Inc.**  
Registered Investment Advisors

WE REALIZE YOUR POTENTIAL.

12511 Cantrell Road • Little Rock, Arkansas 72223  
(501) 223-9190 • 800-635-9985  
[www.hutchinson-ifrah.com](http://www.hutchinson-ifrah.com)



*Pledging commitment is one of the most important things that human beings can do for one another. It means I'll do only my best for you. I'll fight for your rights. I'll be there for you. At Snell Laboratory we*

*make that type of commitment to each of our patients. We dedicate ourselves to making them as comfortable and as mobile as possible. We give them back as much of their former life as we can.*

# A MATCH MADE IN HEAVEN.



*Our computer-aided design and manufacture (CAD/CAM) system makes so much more possible in creating custom-fit prostheses than ever before. And new lightweight, space age materials mean more for our patients with custom orthoses. So regardless of what responsibilities your*

*patients agree to in life, from going out to play to attending a special occasion, our commitment to comfort never waivers.*

*Snell Prosthetic and Orthotic Laboratory has been in business since 1911. We've said "I do" to our patients since day one.*



**SNELL**  
Prosthetic & Orthotic  
Laboratory

THE LATEST IN TECHNOLOGY. THE BEST IN CARE.

Offices located in Little Rock, Russellville, Fort Smith, Mountain Home, Fayetteville, Hot Springs, North Little Rock, and Jonesboro.

Little Rock (501) 664-2624 • Statewide Toll-free 1-800-342-5541

Founding Members of PrimeCare O&P Network - serving the southern United States.



# State Senator Awarded National AMA Award

*Jay Bradford Honored for his Dedication to Health Care Reform*

By CHRISTY L. SMITH

**S**tate Sen. Jay Bradford of Pine Bluff was one of 11 federal, state and municipal government officials to receive a 2000 Nathan Davis Award for Outstanding Government Service on July 18 in Washington, D.C.

The senator said he is "especially grateful" to U.S. Rep. Vic Snyder and Amy Rossi, executive director of Arkansas Advocates for Children and Families, for the nomination.

"Without their support, it would not have come to pass. The honor will bolster my courage to keep fighting to improve the health of my fellow Arkansans," Sen. Bradford said.

Presented each year by the American Medical Association, the award recognizes elected and career officials whose "outstanding contributions have promoted the art and science of medicine and the betterment of public health," according to the AMA. It was named for Nathan Davis, who founded the AMA in 1847.

Sen. Bradford has represented Arkansas' ninth Senate district since 1983. He is president pro tem of the state Senate and chairman of the Senate's Public Health, Welfare and Labor Committee. He also serves on a dozen other committees and subcommittees.

U.S. Rep. Snyder said he nominated Sen. Bradford for the Nathan Davis Award because the senator demonstrates an unfailing commitment to improving the health of Arkansas families.

"I was in the state Senate for six years. Jay was always an advocate for public health and was always looking for ways to improve the health of Arkansans day in and



Sen. Jay Bradford

day out. His number one issue has always been health-related activities. [The award] is a really nice thing. It was a great honor for him and he deserves it," he said.

In his nomination letter, U.S. Rep. Snyder noted that Sen. Bradford has sponsored legislation extending state health care coverage to uninsured children and bills seeking mental health parity, providing individual health care plans to students with special health care needs and calling for research into the health needs of those living with HIV/AIDS.

In addition to advocating a breast cancer research program funded by taxes on tobacco products, Sen. Bradford has assumed a "major role in the debate on the tobacco settlement, maintaining the view

that these funds should be dedicated to treating smoking-related diseases and conducting smoking prevention programs," U.S. Rep. Snyder wrote.

Katherine Waite, the AMA's government affairs assistant, said 31 other state senators were nominated for the Nathan Davis Award this year. The awards also annually recognize a U.S. representative; members of the federal executive branch serving by political appointment, in career public service and in career military service; a governor; a state representative; a member of a city or county government; and a career public servant at the local level.

"Through these awards, the AMA strives to encourage and stimulate recognition for the highest public service standards throughout all levels of government," said Robert J. Mills, the AMA's public information officer. ■





# Hallmarks of Patient Care: History, Examination, Suspicion

J. KELLEY AVERY, MD

The diagnosis in this case was acute epididymitis, which is the usual diagnosis confused with torsion. The onset is usually not sudden, with symptoms beginning a few days before the patient goes to the physician.

A 24-year-old obese man reported to a minor medical center after the sudden onset of pain in the right testicle for one hour. The patient's temperature was 99°F, pulse 86/min, and his blood pressure was normal. He weighed 325 pounds and was 6-feet, 1-inch tall. Documentation of the physical examination was confined to the genitalia, noting only "swollen right testicle/epididymis with tenderness locally. Inguinal canal OK."

The diagnosis was recorded as epididymitis, right. The patient was given an antibiotic by injection and a prescription for the same to be taken by mouth. The instructions given by the physician, though not documented, were said by the patient to be, "Report to the hospital emergency department if pain does not subside."

Four hours later, six hours after onset of pain, the patient reported to the medical center hospital emergency department with the same severe pain in the right testicle. The examination on this occasion revealed a swollen, tender right testicle and epididymis. The remainder of a complete physical examination was within normal limits except for obesity. The history revealed therapy with Dilantin for a seizure disorder. He had not had a seizure for a year, though he took the antiseizure medication irregularly. Urinalysis revealed some protein, and his WBC count was 12,000/cu mm with 89% segmented neutrophils. The admission diagnosis was acute torsion, right testicle.

Operation disclosed a dark blue right testicle, with the cord showing a 540 degree torsion. The torsion was reversed, and exploration of the left testicle showed it to be normal; sutures were placed to fix it in the normal position. The infarcted right testicle was removed, and pathology reported the testicle was indeed dead. The postoperative course was normal, and recovery was complete.

A lawsuit was filed by the patient charging the physician in the minor medical facility with negligence in failure to diagnose the torsion of the testicle resulting in the loss of the testicle and the possibility of infertility. Expert review indicated the physician did not provide treatment to his patient that would meet the prevailing standard of care.

## Loss Prevention Comments

The marked obesity of this patient possibly complicated the physical examination and the

diagnosis, but the history in this case was typical of testicular torsion. The onset was sudden, without any predisposing factors. If seen in the first hour the finding is usually tenderness in the testicle with some swelling. The tenderness is significant, and sometimes the testicle is slightly to moderately swollen. The testicle may lie higher than normal in the scrotum, and careful palpation may occasionally reveal the torsion. The urinalysis may be totally negative. Survival of the testicle is extremely rare after four hours of torsion, so prompt diagnosis and treatment is imperative.

The diagnosis in this case was acute epididymitis, which is the usual diagnosis confused with torsion. The onset is usually not sudden, with symptoms beginning a few days before the patient goes to the physician. Examination more often reveals a tender, swollen testicle that may show some redness, induration and warmth of the skin. The laboratory should show more evidence of infection, with more fever and elevation of the WBC count.

The use of imaging technology has been studied, and as yet the specificity of diagnosing acute torsion of the testicle is not encouraging. One fact that may increase the value of a case like this is that about 25% of these patients are infertile afterwards, likely due to some ischemia of the other testicle triggered by the insult of torsion.

Because of the opinion of the specialists who studied this case, and the unanimous opinion that the physician was outside the standard of care, a modest settlement was negotiated. The hallmarks of this diagnosis appear to be a good history, a good examination and a high index of suspicion for the condition. None of these seemed to be present here, or if they were, they did not appear in the medical record. ■

*The case of the month is taken from actual Tennessee closed claims. An attempt is made to fictionalize the material in order to make it less easy to identify. Dr. Avery is a member of the Loss Prevention Committee, State Volunteer Mutual Insurance Co., Brentwood, Tenn. This article appeared in the May 2000 issue of Tennessee Medicine. It is reprinted with permission.*



## CT Scans are Helpful in Acute Abdomen Cases

EDITOR AND AUTHOR: STEVEN NOKES, MD — AUTHOR: JOSUE MONTANEZ, MD

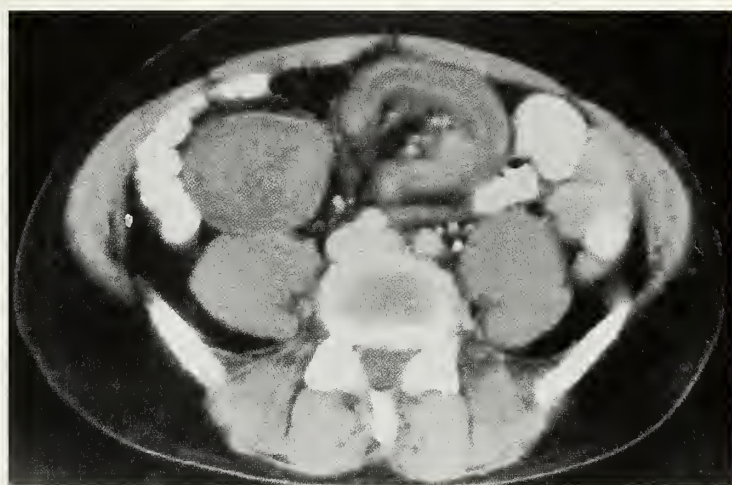
### History

A 50-year-old man presented to the emergency department with right lower quadrant pain. Plain films were unremarkable and a CT scan was performed (Figures 1-3).

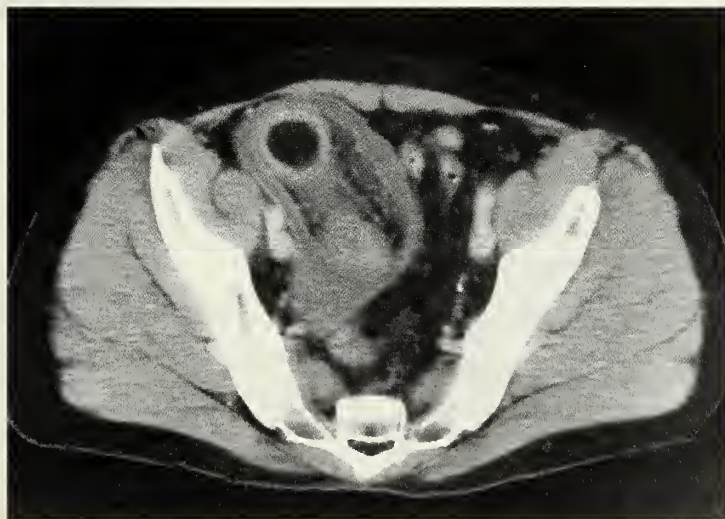
### Findings

Figure 1 reveals a poorly defined target sign within the cecum consisting of alternating layers of bowel and fluid. In the center of the image is a reniform mass with mesenteric fat and vessel intussuscepting into small bowel. Figure 2 shows a 2-centimeter low-density lipoma within the right lower quadrant. This was the lead point. This is well defined on the coronal reconstruction (Figure 3).

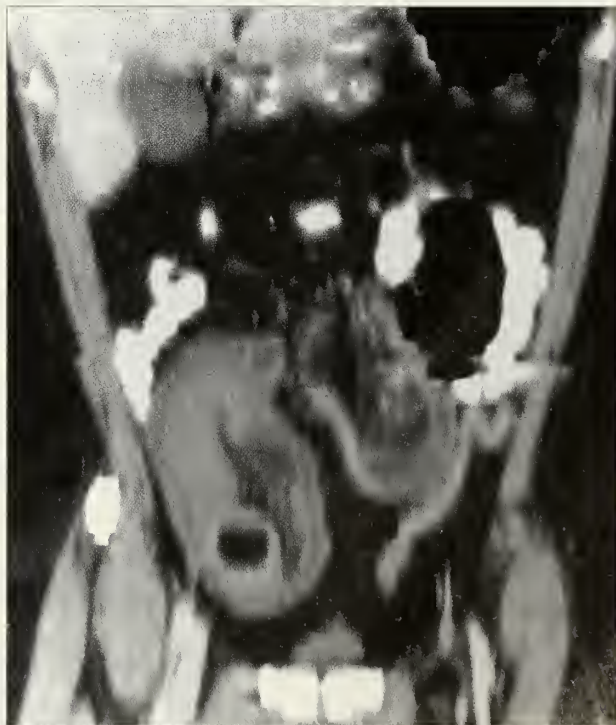
**Diagnosis:** Ileocolic intussusception



**Figure 1.** CT scan of the abdomen.



**Figure 2.** CT scan of the abdomen.



**Figure 3.** Coronal reconstruction of the helical data.



*What you pay for.* **CENTRAL**  
FLYING SERVICE



*What you get.* **SKYSHARE**



For more information about what **SKYSHARE** can mean to you call Cheri McKelvey at 375-3245 x321

## ACHIEVING SUCCESS ENTITLES YOU TO PRIVILEGES IN LIFE

Achieving your personal goals often requires a planned balance of financial management, including checking, loans, trust, investment products\* and services.

At Regions, we offer Private Banking to complement your success. We provide a level of service to efficiently meet your needs and maximize your valuable time. Whether you require business or personal services, you can rely on one of our private bankers to help ensure your goals are met by provided uncompromising, convenient service. To find out more about the special attention you deserve, please call us today.

Contact our Private  
Banking Department  
371-6613

**PRIVATE  
BANKING**

**Regions Bank**

[www.regionsbank.com](http://www.regionsbank.com)



\* Investments purchased through Regions Investment Company, Inc. are not deposits of the bank or guaranteed or insured by the bank, the FDIC or any government agency. Investments can assume risk including loss of principle. Regions is a member of NASD and SIPC.

MEMBER  
FDIC

### Discussion

CT has become an integral part of the work up of the acute abdomen. It is particularly helpful in the work up of appendicitis, diverticulitis and small bowel obstruction (SBO), where the accuracy of CT is 95-100%.

The most common cause of SBO is an adhesion secondary to prior surgery. Hernias are the second leading cause. Less common causes include tumors, intussusception and closed loop obstruction. CT allows a specific preoperative diagnosis of intussusception. Early cases demonstrate a doughnut sign due to mesenteric fat extending into the bowel wall. Later a target sign is encountered with alternating layers of differing attenuation reflecting closely applied bowel wall, mesenteric fat, mesenteric vessel, intestinal fluid, gas and sometimes contrast. This is analogous to the "coiled spring" appearance seen on barium studies. A reniform mass suggests associated bowel ischemia (as in this case). Fifty percent of colonic intussusceptions in adults are secondary to malignant neoplasms. Lipomas of the ileocecal valve are the second most common cause. In our case, a submucosal ileal lipoma was the leading edge, confirmed at surgery. Several feet of gangrenous ileum were removed. ■

### References:

1. Urban BA, Fishman EK. Targeted helical CT of the acute abdomen. Appendicitis, diverticulitis and small bowel obstruction. *Sem in US, CT and MRI* 2000; 21:20-39.
2. Parienty RA, Lepreux JF, Gruson B. Sonographic and CT features of ileocolic intussusception. *AJR* 1981; 7 136: 608-610.
3. Merine D, Fishman EK, Jones B, Siegelman SS. Enteroenteric intussusception: CT findings in nine patients. *AJR* 1987; 148: 1129-1132.

*Drs. Nokes and Montanez are with Radiology Consultants of Little Rock.*

## Arkansas Country Doctor Museum

**September 29 - October 1**



Lincoln's Annual Apple Festival will be held. The Arkansas Country Doctor Museum, just one block from the Town Square at 107 N. Starr Ave., will host a gala open house from 10 a.m.-5 p.m. Sept. 29. The open house will continue from 10 a.m.-5 p.m. Sept. 30 and Oct. 1. A special exhibit of wood-carvings by local artist Barbara Griscom also will be on display. Folk music by Fireside Friends will begin at 1 p.m. Sept. 30.

**October 7**



Phillip Steele, author of "The Family Story of Bonnie and Clyde," will talk about his latest book at 2 p.m. at the museum.

**October 17**



The Country Roots Genealogy Society will meet at 6:30 p.m. at the museum.

The Arkansas Country Doctor Museum, located in Lincoln, is currently developing a docent program and is raising funds for the Hall of Honor project, which will honor Arkansas' country doctors, past and present. ■

For more information on the museum or to donate, call (501) 824-4307, e-mail [acdm@pgtc.net](mailto:acdm@pgtc.net) or visit [www.drmmuseum.net](http://www.drmmuseum.net).

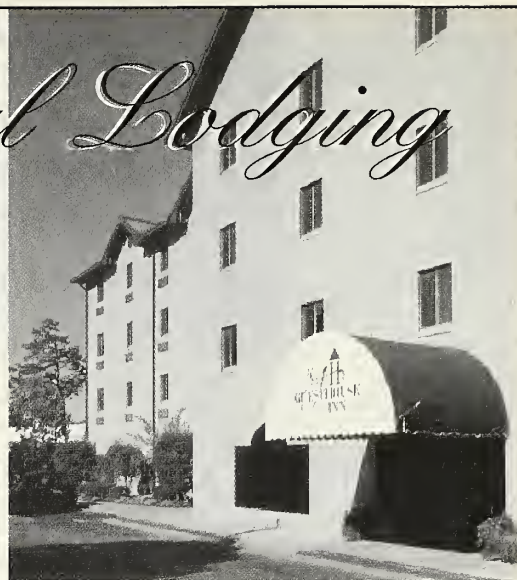
## Medical Lodging

*Close proximity to all  
Little Rock hospitals*

Serving Little Rock Visitors

- Medical stays
- Business travel
- Leisure travel

*"Guesthouse Inn is your  
perfect home away from home  
while in Little Rock"*



301 So. UNIVERSITY AVE. ▲ LITTLE ROCK, AR 72205 ▲ (501) 664-6800

## Board Certified Emergency Physicians needed in Central Arkansas

ARE YOU TIRED?  
ARE YOU LOOKING  
TO SLOW DOWN?

We need you in our soon-to-be renovated 11,000 volume ED in central Arkansas. BC Emergency Medicine staff physicians and a Medical Director are needed. Remuneration is \$100.00/hr., procured mal-practice and Independent Contractor status. Please contact **Traci Mahlmeister** with PhyAmerica at **800-476-5986**, fax CV to **919-382-3274**. All inquiries are confidential.



**PhyAmerica**  
Physician Services, Inc.



# CARDIOLOGY



## Anticoagulation Management in Mechanical Heart Valve Patients Who Undergo Dental Procedures

JILL T. JOHNSON, PHARM.D. — MARK C. GRANBERRY, PHARM.D. — AUDRA R. THOMAS, PHARM.D.  
EDITOR: EUGENE S. SMITH, MD

*This month's case discusses a rather common problem faced in patients receiving anticoagulation. Often primary care specialists or cardiologists must make recommendations regarding warfarin therapy before and after dental procedures. This review seeks to help practitioners balance between over and under anticoagulating these patients during the peri-procedural period.*

### Patient Presentation

**History:** A 66-year-old female requiring anticoagulation with warfarin s/p aortic valve replacement with a St. Jude valve was planning to undergo dental surgery. She was known to have had a coronary artery bypass graft, a gastrointestinal (GI) bleed in the past, and decreased left ventricular function with an ejection fraction of 25-30%. Her target international normalized ratio (INR) was 2.0-2.5 due to her history of GI bleeding. Her home medications included warfarin 6 mg daily for six days per week with 4 mg on Mondays, valsartan 80 mg every day, amlodipine 10 mg every day and calcium 600 mg twice daily. She was not taking aspirin secondary to her GI bleeding history.

Four weeks prior to her dental

procedure her INR was 1.9. Two days prior to her dental procedure she was instructed to skip her warfarin doses and to restart her current warfarin regimen when she returned home after the procedure. She underwent decalcification of six teeth in which her gums were cut and the teeth were rebuilt. Two days after her procedure, her INR was 1.6. One month after her procedure, no thrombotic event had been reported. Her INR at that time was 2.5.

### Discussion

Long-term anticoagulation with warfarin is the standard of care to

prevent thromboembolism for patients with mechanical prosthetic heart valves. When these patients require oral surgery procedures, questions frequently arise on how to best manage their anticoagulation. Due to the perceived likelihood of significant bleeding, anticoagulation is often interrupted during the days surrounding the procedure. However, even short-term discontinuation of anticoagulation may place the patient at significant risk for thromboembolism. Therefore, before anticoagulation is interrupted, the potential of significant bleeding must be weighed against the increased

**Table 1.**

Summary of ACC/AHA recommendations for management of anticoagulation in patients with mechanical heart valve replacements planning to undergo dental surgery.

#### All types of mechanical heart valves

Discontinue aspirin 7 days before procedure

#### Low thromboembolic risk

Stop warfarin 2-3 days before procedure; allow INR to fall to 1.5. Restart warfarin within 24 hours of procedure.

#### High thromboembolic risk

Stop warfarin. Administer heparin when INR falls below 2.0. Stop heparin 4-6 hours before procedure. Restart warfarin within 24 hours of procedure.

thromboembolic risk.

The rate for thromboembolism associated with mechanical heart valves without anticoagulation varies from 3-13% per year and is dependent on type and placement of prosthesis. Aortic placement of a mechanical valve carries the lowest risk for thrombosis with mitral placement and the

combination of aortic with mitral placement having relatively higher thromboembolic risks.<sup>1,2</sup> In addition, tilting disc valves and bileaflet valves have a lower embolic risk than caged ball valves. Without anticoagulation, the risk for major embolism is four events per 100 patient-years while the risk for valve thrombosis is 1.7 events per 100 patient years. With sufficient anticoagulation, these risks are reduced by 75% per year. The risk for thromboembolism is greater the longer anticoagulation is held and is estimated to be 0.016% for one day of interruption. For example, if anticoagulation was withheld for four days surrounding a dental surgery procedure, the risk of any thromboembolic event would be  $4(4 + 1.7)/365 = 0.062\%$ , or 6.2 in 10,000, compared to only 3.1 in 10,000 if the anticoagulant was held for only two days.<sup>2</sup> If a thrombus forms, it likely forms slowly over as long as two

months. Therefore, absence of a thrombotic event occurring early after interruption of anticoagulation may give the clinician a false sense that the patient has not suffered or will not suffer any thrombotic consequence. Some practitioners hospitalize patients to discontinue warfarin and initiate heparin to minimize the time the patient spends without anticoagulation. Others allow the patient to stop warfarin without any other means of anticoagulation because they believe the thrombotic risk to the patient is negligible.<sup>3</sup>

The incidence of bleeding is 1.4 per 100 patient-years with oral anticoagulation therapy alone and 4.6 per 100 patient-years when an antiplatelet is added.<sup>2</sup>

Dental procedures such as routine teeth cleanings, fillings and crowns have not been shown to increase the risk for bleeding in anticoagulated patients.<sup>4</sup> Therefore, it is reasonable

to continue full anticoagulation in patients undergoing these procedures.

The American College of Cardiology and the American Heart Association currently recommend the management of anticoagulation in patients with mechanical heart valve replacements planning to undergo dental surgery be individualized. The risk of bleeding during the procedure should be

considered; dental cleaning and treatment of dental caries should be completed without discontinuing anticoagulation. (Table 1) If the patient is taking aspirin, it should be discontinued seven days before the procedure and be restarted the day after the procedure or after active bleeding ceases. The ACC/AHA also recommend that warfarin be stopped two-three days before a dental procedure to allow the INR to drop to 1.5 or below and to restart warfarin within 24 hours of the procedure. For patients at high risk for thromboembolism, heparin should be started once the INR falls below 2.0 and stopped four-six hours before the procedure. (Table 2) High risk is defined as having a thromboembolism within the previous year, a Bjork-Shiley valve in any position or having previously suffered thromboembolism when off warfarin therapy. If a patient has three or more risk factors including any type of

**Table 2.**

Factors that place a patient at a high thromboembolic risk.

**Risk Factors**

- ◆ Thromboembolism during the previous 1 year
- ◆ Bjork-Shiley valve in any position
- ◆ Previous thromboembolism when off warfarin
- ◆ Any of 3 of the following:
  - > Mechanical heart valve in the mitral position
  - > Atrial fibrillation
  - > Ejection fraction <30%
  - > Hypercoagulable condition
  - > Previous thromboembolism

**Table 3.**

Trials of tranexamic acid mouthwash (TAM) in mechanical heart valve patients undergoing dental surgery.

Study	Type of procedure	Comments	Conclusion
Souto, <i>et al.</i> <sup>6</sup>	Tooth extractions	Anticoagulant dose was decreased for 2 days	Bleeding was significantly reduced by TAM
Sindet-Pedersen, <i>et al.</i> <sup>7</sup>	Oral surgery	Placebo-controlled, double-blind, randomized; anticoagulant doses were not decreased	Statistically fewer bleeding episodes with TAM
Borea, <i>et al.</i> <sup>8</sup>	Single dental extraction	TAM without altering the anticoagulant dose vs. placebo while discontinuing mouthwash	No difference between the 2 groups
Ramstrom, <i>et al.</i> <sup>9</sup>	Oral surgery	TAM vs. placebo; neither group discontinued anticoagulant	The placebo mouthwash group experienced more bleeding



## There are plenty of full service banks. So where are all the full service bankers?

If you want the type of personal service that's missing from most full service banks these days, call Metropolitan National Bank's Professional Banking Group. Our highly specialized team, led by Senior Vice President George Penick (978-7632), focuses exclusively on helping those with substantial assets, but limited time to maximize their potential.

Just make the SimpleSwitch to our Professional Banking Group at Metropolitan. We'll give you the personal service you've been looking for.



Little Rock, North Little Rock, Sherwood,  
Benton, Bryant and Conway

N E A R B Y & N E I G H B O R L Y .

www.metbank.com

Member FDIC



fibrillation, LV dysfunction (EF<30%), a hypercoagulable condition and previous thromboembolism, heparin should also be instituted. Heparin should also be initiated in a patient with any mechanical heart valve type in the mitral position if any additional risk factor exists.<sup>5</sup>

An alternate strategy to minimize both the risks of bleeding due to dental surgery and thromboembolism due to interruption of anticoagulation is to maintain systemic anticoagulation while creating a localized area of near normal coagulation around the surgical site. Tranexamic acid has been evaluated in a mouthwash form as a local antifibrinolytic agent.

Three studies evaluating the use of tranexamic acid mouthwash in mechanical heart valve patients undergoing extractions or oral surgery demonstrated that patients receiving the antifibrinolytic mouthwash experienced fewer bleeding episodes than the control groups. Another study found there to be no difference between those who received mouthwash without altering the anticoagulant dose versus placebo mouthwash while discontinuing the anticoagulant. (Table 3)

### Conclusion

The management of anticoagulation in mechanical heart valve replacement patients undergoing dental procedures must be individualized. Consideration must be given to the type and position of the valve, the patient's previous thrombotic history when left unanticoagulated and other risk factors for thrombosis. The risk of procedure related bleeding for anticoagulated patients must be weighed against the potential for thrombotic consequences in patients whose anticoagulation is interrupted. Tranexamic mouthwash is one alternative for reducing the risk for local bleeding during and after oral surgery without interrupting systemic anticoagulation. ■

### References

1. Kontos GJ, Schaff HV. Thrombotic Occlusion of a prosthetic heart

At the  
**HEART**  
of quality  
health care...



...there's  
**HealthLink.**

*HealthLink of Arkansas  
is proud to offer:*

- Convenient service
- Strong multi-payor distribution channel
- Flexible health care programs
- Well-established regional network
- Responsive local presence

**Join HealthLink Today!**

**1-877-284-0101**

**HealthLink**  
of Arkansas



Managed Health Care

- valve: diagnosis and management. Mayo Clin Proc. 1985;60:118-22.
2. Cannegieter SC, Circulation 1994;89:635-41.
  3. Tiede DJ, et al. Management of Prosthetic Valve Anticoagulation. Mayo Clin Proc. 1998;73:665-80.
  4. Benoliel R, Leviner E, Katz J, et al. Dental treatment for the patient on anticoagulant therapy: Prothrombin time value-what difference does it make? Oral Surg Oral Med Oral Pathol. 1986;62:149-151.
  5. Bonow RO, Carabello B, de Leon Jr AC, et al. ACC/AHA guidelines for the management of patients with valvular heart disease: A report of the American College of Cardiology/American Heart Association (Committee on management of patients with valvular heart disease). J Am Coll Card. 1998;32(5):1486-1582.
  6. Souto JC, Oliver A, Zuazu-Jausoro IZ, et al. Oral Surgery in Anticoagulated Patients without reducing the dose of oral anticoagulant: A prospective randomized study. J Oral Maxillofac Surg. 1996;54:27-32.
  7. Sindet-Pedersen S, Ramstrom G, Bernvil S, et al. Hemostatic effect of tranexamic acid mouthwash in anticoagulant-treated patients undergoing oral surgery. N Engl J Med. 1989;320:840-3.)
  8. Borea G, Montebugnoli L, Capuzzi P, et al. Tranexamic acid as a mouthwash in anticoagulant-treated patients undergoing oral surgery. Oral Surg Oral Med Oral Pathol. 1993;75:29-31.
  9. Ramstrom G, Sindet-Pedersen S, Hall G, et al. Prevention of postsurgical bleeding in oral surgery using tranexamic acid without dose modification of oral anticoagulants. J Oral Maxillofac Surg. 1993;51:1211-16.

*Drs. Johnson, Granberry and Thomas are with the College of Pharmacy, University of Arkansas for Medical Sciences in Little Rock. Dr. Smith is with the College of Medicine, UAMS.*



**ACE**  
AIR CHARTER EXPRESS

**24 HOUR AIR CHARTER  
& AIR FREIGHT FAA CERTIFIED**

**Full Service  
FBO**

**501-833-5600**

- Flight Training
- Maintenance (pistons, turbines, jets)
- Pilot Services
- Fuel Sales (full service & self service)



*Committed to Personal Service!*

## M E D I C A L   O F F I C E S P A C E

**DOCTORS BUILDING**  
500 South University Avenue  
Little Rock, Arkansas

Suites Available ranging from  
950 sq. ft. to 4,807 sq. ft.

Professional Management  
Maintenance 24 hours a day, 365 days a year  
Nightly janitorial service plus Day Maid  
Free Doctors Parking Lot -  
Or Low Cost Reserved Parking  
Free Use of Well Appointed Conference/Club Room  
Ancillary Services in Building

**Location convenient to all area Hospitals**  
including Baptist, St. Vincent Doctors,  
St. Vincent Infirmary, UAMS, VA  
and Arkansas Children's.

**CONTACT**  
**Betty Garcia - 664-1812**  
VISIT OUR WEBSITE [www.lрма.com](http://www.lрма.com)



# The Reality of Mammography Utilization in the State of Arkansas

ABDUL RAHMAN JAZIEH, MD MPH — INDU SOORA, MPH, CHES — HARRY MOHRMANN, MS

The Arkansas Mammography Data Collection Project, funded by the Arkansas Department of Health, aimed to determine the mammography screening patterns throughout the state of Arkansas. Data were obtained from 92 mammography centers out of 112 centers (82%).

A total of 157,976 mammography data sets were obtained for 148,586 women. Mammography rate was 22.7% for women 40 years and older and 24.1% for women 50 years and older. Mammography rates per county varied from 0.3% to 42.6%. The overall low rate of mammography utilization reflects the need to intensify public health interventions and continuous evaluations of these interventions.

## Introduction

Breast cancer is the second leading cause of cancer death in women in the United States. It is estimated that 176,300 new cases of breast cancer with 43,700 related deaths occurred in 1999.<sup>1</sup> In Arkansas, 381 women died from breast cancer in 1998.<sup>2</sup>

Early detection provides survival advantage and better chance of cure for women with breast cancer. Since mammography is currently the best mass screening tool available, it is imperative that women over age 40 undergo screening mammography routinely.<sup>3-7</sup>

In Arkansas, 49% of the population resides in rural areas with 16% of the population being African-American. Furthermore, African-Americans constitute about 50% of the population of the Delta region. These facts present a challenge in terms of public health planning and interventions. Therefore, BreastCare of the Arkansas Department of Health funded several interventions

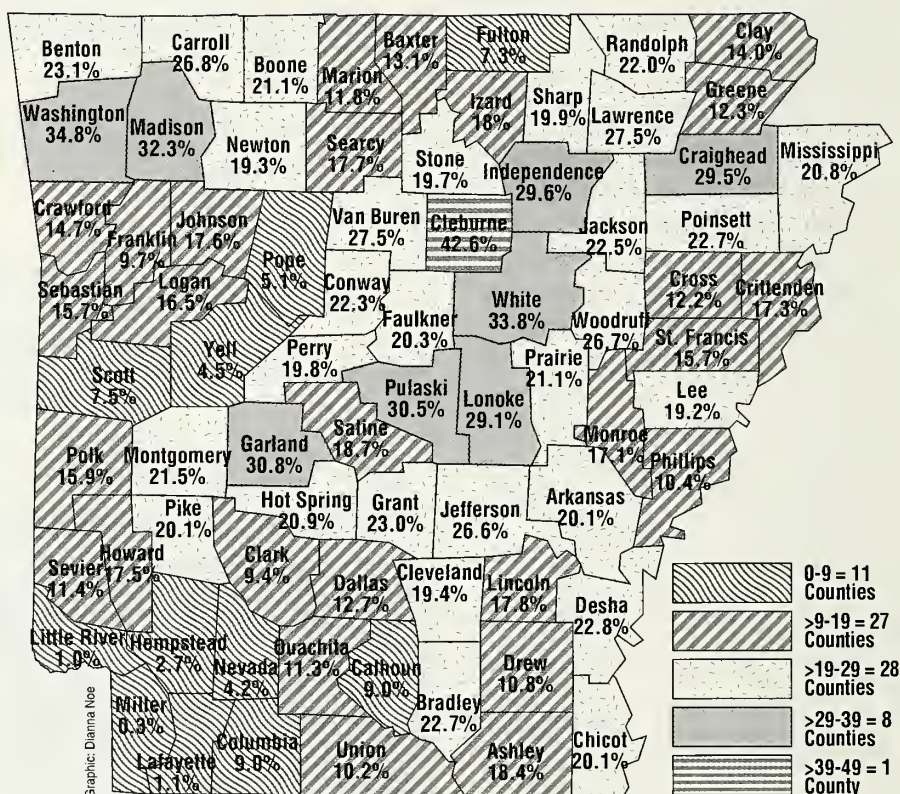


Figure 1: Mammography rates in each county for women 40 years and older.

that promote early detection, diagnosis and treatment of breast cancer in Arkansas.

## Arkansas Mammography Data Collection Project (MDCP)

The MDCP was funded by BreastCare to compile and analyze the mammography data for the state of Arkansas during 1997. The purpose of the project was to determine the mammography rates and describe screening practice patterns at the state and county levels.

All 112 FDA approved mammography centers were contacted and

requested to participate in the project. Data elements inquired from the participating centers were: date of birth, race (Caucasian, African-American, other, unknown), ethnicity (Hispanic or non-Hispanic), insurance status (private, Medicare, Medicaid, none, unknown), date of mammogram, type of mammogram (screening, diagnostic or unknown) and zip code of residence. The data was entered into the specifically designed Access™ database. Analysis was performed to determine the pattern of mammography utilization by age, race, mammography type and insurance status. The mammography rate and the

mammography rate by race were calculated using the MDCP database and the 1997 estimated census data.

## Results

Out of 112 mammography centers, 92 centers participated in the project (82%). The estimated total number of mammograms performed was 202,606. The MDCP collected 157,976 mammography data sets from the participating centers due to nonparticipation of 20 centers. The total number of individual women imaged was 148,586 and 90% of them were women ages  $\geq 40$  years ( $N=133,549$ ). The analysis was performed mainly on the latter group of women.

Only 22.7% of women ages  $\geq 40$  years had mammograms. The rate was slightly higher for women ages  $\geq 50$  year (24.1 %). Age was unknown for only 3% of the women imaged (Table 1). The mammography rates by each county are depicted in Figure 1 and it ranges from 0.3% (Miller County) to 42.6% (Clebune County).

The screening mammograms were most prevalent (61.2%) followed by diagnostic mamm-ograms (34.7%), with only 4% of the mammography type unknown (Table 2). The race information was available for approximately 50% of the women imaged. Determining the mammography rates by race showed a lower rate for African-Americans as compared to Caucasians and other categories (7.8%, 11.4%, and 11%, respectively).

Private insurance was the most common type of insurance among these women (46.9%), followed by Medicare (18.4%) and both (5%). Only 1.6% had Medicaid and 6% were uninsured. Insurance status was not known in 22.3% of women.

## Discussion

In spite of the large number of mammography centers, the retrospective nature of the project, and many barriers encountered, the MDCP staff

were able to secure the participation of 82% ( $N=92$ ) of the mammography centers in Arkansas. This fact reflects the support and collaboration of the health care organizations in Arkansas to such public health projects. On the other hand, the mammography rate is noticeably low since less than 25% of the women 40 and older obtained mammograms in 1997. Even if adjusted for missing data, less than one third of

**Table 1.**

Mammography Rates by Age in the Participating Centers Using 1997 Estimated Census Data.

Age Groups	Rate
30-39	4.9%
40-49	19.4%
40-above	22.7%
50 and above	24.1 %

the women obtained mammograms. The mammography rates are remarkably variable, with 11 counties having mammography rates in single digits. Only one county has a mammography rate more than 40%. These results should alarm the health care providers and public health professionals to intensify their efforts to

may be attributed to the fact that October is Breast Cancer Awareness Month.

This MDCP baseline data will assist in evaluating the effectiveness of public health interventions. Therefore, a similar project should be conducted in the future to determine trends in the mammography rates in Arkansas. These results also identified certain geographical regions in the state with very low rates. Further evaluation of these areas is needed to better understand the reasons and the best way to remedy this problem. Establishing statewide tumor registry would be of great value to accomplish all these results and it will complement the efforts of other states that already established such activity with the support of the National Cancer Institute Breast Cancer Consortium.<sup>8-11</sup>

## Conclusion and Future Direction

The majority of the women in Arkansas did not have mammograms in 1997. Health care providers and public health professionals should enhance their efforts to increase the number of women obtaining mammograms.

The MDCP is the first project ever to compile mammography data in a systematic and comprehensive manner in the state of Arkansas. Similar future projects or even establishing statewide mammography registry are warranted to determine mammography trends and to evaluate the efficacy of the ongoing public health interventions.

For more detailed information, visit the web site at [www.acrc.uams.edu/mdcp](http://www.acrc.uams.edu/mdcp).

## Acknowledgments

The authors are indebted to Rebecca Morris-Chatta, MPH, for all her help throughout the project. The project was supported by a grant awarded by the Arkansas Department of Health. ■

**Table 2.**

Mammography Rates by Exam Type in the MDCP Database for Women 40 and Older.

Type of Mammogram	MDCP	Percentage Data
Screening	81,649	61.2%
Diagnostic	46,386	34.7%
Unknown	5, 514	4.1%
Total	133,549	100%

increase the number of women having mammograms through various public and professional educational interventions.

It is intriguing to notice that the monthly mammography rates were fairly consistent between 10,000 and 14,000 mammograms per month, except for October, in which 16,311 mammograms were performed. This



# SERVING ARKANSAS' HEALTHCARE INDUSTRY

WHEN YOUR INSURANCE NEEDS ARE UNIQUE,  
YOU WANT AN AGENT AND INSURANCE  
COMPANY THAT THINK LIKE YOU DO—  
INDEPENDENTLY

Let's face it: not every insurance company will have the right insurance choices for the unique needs of the health care industry in Arkansas.

Hoffman-Henry doesn't work for any insurance company. We work for you. And our obligation is to help you find the right policy for your needs. From the right company. At the right price.

When it comes to independent thinking for the Arkansas medical community, we recommend St. Paul Fire and Marine Insurance Company. They specialize in the health care industry and will work closely with us to meet your unique insurance needs.

Call one of our three locations for a free review and consultation- before your current coverages expire.



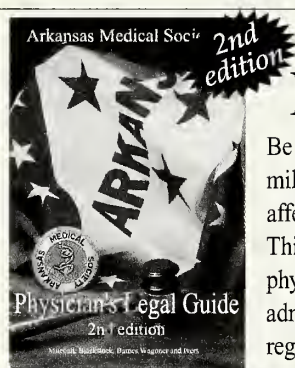
**H** Hoffman-Henry  
Insurance Corporation



**The St Paul**

*It pays to make the independent choice.*

Little Rock 501-224-8884 • Pine Bluff 870-534-4532 • Searcy 501-268-3528



## Arkansas Medical Society's Physician's Legal Guide

Be one of the first to obtain this guide which contains a multitude of state and federal laws affecting the practice of medicine. This guide is a valuable resource for physicians, clinic and hospital administrators, office staff, attorneys, regulators and many others.

**\$65.00\***  
for AMS  
members  
**\$87.00\***  
List Price  
Prices include  
shipping and handling.

Check enclosed in the amount of: \$ \_\_\_\_\_

Please charge my Visa or Mastercard:

☐ Please check if you are  
an AMS member.

Cardholder's name: \_\_\_\_\_

Credit card No.: \_\_\_\_\_ Exp. date: \_\_\_\_\_

Cardholder's Signature: \_\_\_\_\_

Name: \_\_\_\_\_

Clinic: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Fax No.: ( ) \_\_\_\_\_

CREDIT CARD ORDERS CAN BE FAXED TO: (501) 224-6489

Call the AMS office at 501-224-8967 or 800-542-1058 for volume discount pricing.

## References

1. Landis SH, Murray J, Bolden S, and Wingo PA. Cancer Statistics, 1999. CA: A Cancer Journal for Clinicians 1999;49(1):8-31
2. Greg Potts. Breast Cancer Screening Increasing. Arkansas Health Counts 1999;5(2):1-3.
3. Shapiro S, Venet W, Strax P, Venet L. Periodic screening for breast cancer: the Health Insurance Plan Project and its sequelae, 1963-1986. Baltimore: Johns Hopkins University Press, 1988.
4. Tabar L, Fagerberg G, Duffy SW, Day NE. The Swedish two county trial of mammographic screening for breast cancer: recent results and calculation of benefit. J Epidemiol Community Health 1989; 43:107-114.
5. Eddy DM. Screening for breast cancer. Ann Int Med 1989; 111:389-399.
6. Kerlikowske K, Grady D, Rubin SM, et al. Efficacy of screening mammography: a metaanalysis. JAMA 1995; 273:149-154.
7. Smart AR, Hendrick E, Rutledge III JH, Smith RA. Benefit of mammography screening in women ages 40-49 years: current evidence from randomized controlled trials. Cancer 1995; 75:1619-1626.
8. Carney PA, Poplack SP, Wells WA, Littenberg B. The New Hampshire Mammography Network: Development and design of a population-based registry. AJR 1996;167:367372.
9. Yankaskas BC, Jones MB, Aldrich TE. The Carolina Mammography Registry. A populationbased mammography and cancer surveillance project. J Registry Management 1996; 23:175-178.
10. Geller BM, Worden JK, Ashley JA, Oppenheimer RG, Weaver DL. Multipurpose Statewide Breast Cancer Surveillance System: The Vermont Experience. J Registry Management 1996; 23:168-174.
11. Ballard-Barbash R, Taplin SH, Yankaskas B, Ernster VL, Rosenberg RD, Carney PA, Barlow WE, Geller BM, Kerlikowske K, Edwards BE, Lynch CG, Urban N, Chervala CA, Key CR, Poplack SP, Worden JK, and Kessler LG. Breast Cancer Surveillance Consortium: A national mammography screening and outcomes database. AJR 1997;169:1001-1008

*Drs. Jazieh, Soora and Mohrmann are with the University of Arkansas for Medical Sciences.*



# PEOPLE+EVENTS

## HONORED

### Searcy Physician Named Distinguished Alumni

Dr. Thomas A. Formby, a family practitioner in Searcy, received the Distinguished Alumnus Award for 2000 by the College of Medicine at the University of Arkansas for Medical Sciences.

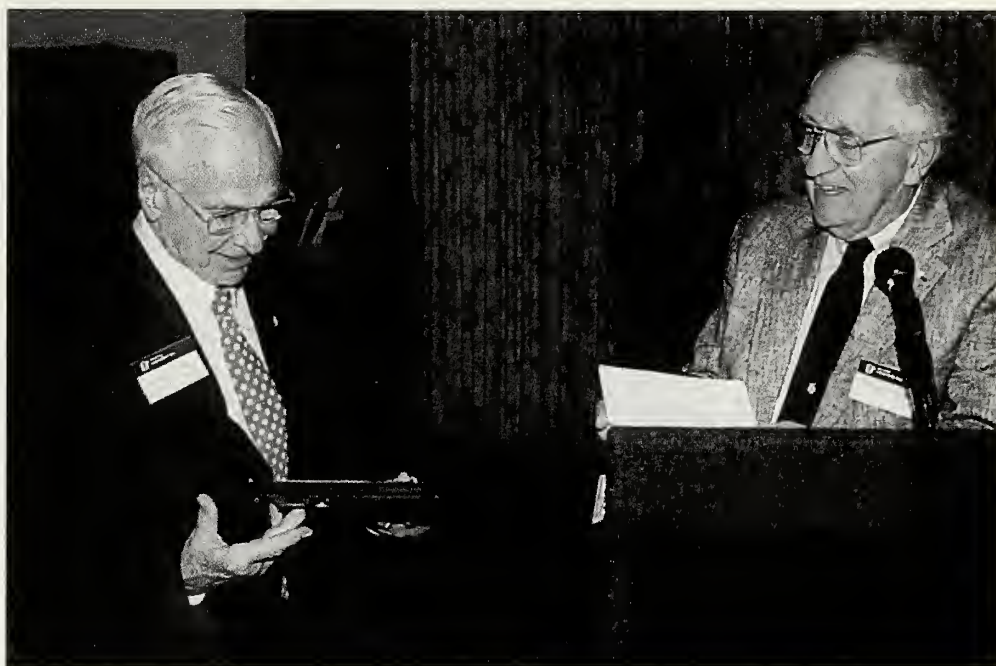
Dr. Formby earned his medical degree from UAMS in 1950. He was one of the first World War II veterans to enter UAMS' medical school on the GI Bill. Dr. Formby continued his training at City Receiving Hospital in Detroit and returned to Arkansas as a small town family physician.

He also was instrumental in opening a community-based hospital, White County Medical Center, which has been thriving while similar hospitals have closed.

### Jacksonville Doctor's Life Honored

A fund-raiser was recently held in Jacksonville for an endowment that will help family practitioners finish their residencies at the University of Arkansas for Medical Sciences. The endowment is named after Dr. James R. Weber, a Jacksonville family practitioner who practiced medicine for more than 30 years before dying in November 1998 of brain cancer.

Dr. Weber also taught



*Dr. Thomas A. Formby of Searcy receives the 2000 Distinguished Alumnus Award from his classmate, Dr. Junius Cross.*

for more than 25 years at UAMS' department of family and community medicine. In recognition of his many contributions to medicine and medical education, UAMS created the James R. Weber Endowment in Family Medicine Residency Education. The endowment has raised \$100,000 in pledges; the goal is to raise \$500,000.

Part of the income of the endowment will help to pay the salary of Dr. Weber's wife, Cynthia Weber, who teaches UAMS family practice residents how to manage a medical practice and is serving as this year's Arkansas Medical Society Alliance president.

Among those in attendance were Dr. Charles H. "Shot" Rodgers, Dr. Alan Storeygard, Dr. Dan Knight,

U.S. Rep Vic Snyder and Dr. I. Dodd Wilson.

### AMA Names PRA Recipients

Each month the American Medical Association presents the Physician's Recognition Award to those who have completed acceptable programs of continuing education.

AMA recipients for May include Drs. Devon R. Ballard, Robert J. Belk, Kimberly L. Cadle, Christopher J. Danner, Robert D. Dickins, Laura L. Eckles, James P. Florez, Kamil I. Hanna, Stephen A. Hathcock, Christina A. Jetton, David C. Kolb, Chris A. Meeker, John M. Mhoon, Steven R. Nokes, Paul H. Pappas, Lila P. Pappas, Grzegorz A. Pitas, Lucas O. Platt and Britton C. Wells

of Little Rock; William L. Diacon of Rogers; Ivy V. McGee-Reed of North Little Rock; Drs. Elizabeth B. Nelson, Christopher Van Asche and John S. Stockburger of Fort Smith; William S. Stubblefield of Brookland, Ark.; and Jon A. Tarpley of Texarkana, Ark.

### Fort Smith Doctor Broadcasts from Italy

Dr. Lonnie E. Harrison, a vascular and cardiac interventionalist physician from Fort Smith, participated May 17 in the "Vascular Interventions 2000" international conference in Milan, Italy.

In a live case broadcast, Dr. Harrison and an Italian colleague demonstrated the technique and safety of cutting balloon angioplasty for correcting heart disease.



Dr. Harrison is regarded as one of the world's experts on the procedure and is a proctor for cutting balloon angioplasty for the United States. He currently is proctoring the Arkansas Heart Hospital in Little Rock and is chief of cardiology at the Oshner Clinic in New Orleans, University of Alabama and several other major cardiac programs in the country.

Dr. Harrison also was an investigator in the FDA Cutting Balloon Angioplasty registry, and all his cases now have been audited. He presented the FDA with a 0% mortality and 0% major adverse cardiac event statistics. In Arkansas, cutting balloon angioplasty is only available at Sparks Regional Medical Center in Fort Smith.



*Dr. Lonnie Harrison of Fort Smith, second from left, participates in a live case broadcast in Milan, Italy.*

## EVENTS

### **Cancer Summit To Fight Disease**

The first-ever Arkansas Cancer Summit for health care professionals will be held from 8 a.m.-6 p.m. Sept. 28 at the North Little Rock Hilton Inn, 2 Riverfront Place.

The summit, sponsored by the Arkansas Department of Health, American Cancer Society, Centers for Disease Control and Prevention and the Breast and Cervical Cancer Control Program, will include sessions on policy and legislative successes in cancer control planning, Arkansas' current state of health affairs, state-of-the-art techniques for cancer screening and treatments and the Arkansas Central Cancer Registry.

Arkansas ranks 16th in cancer mortality rates among the 50 states. Although many other states have developed collaborative plans to fight cancer, Arkan-

sas has yet to do this. The Arkansas Cancer Summit will help decrease duplication in cancer services and develop better ways to control the disease.

Actor and cancer survivor Ann Jillian will be the keynote speaker. Registration fee is \$50. Call the American Cancer Society at 603-5200. ■

### **Resolution**

**Aubrey M. Worrell Jr., MD**

WHEREAS, the members of the Jefferson County Medical Society are deeply saddened by the death of an esteemed member, Aubrey M. Worrell Jr., MD; and

WHEREAS, Dr. Worrell's dedication to his profession was evidenced by many years of membership in this Society, the Jefferson County Medical Society, the Arkansas Pediatric Society, the American Academy of Pediatrics and the International Academy of Nutrition and Preventive Medicine, and as a valued member of the medical staff at Jefferson Regional Medical Center, and

WHEREAS, Dr. Worrell served his country and his fellow man as a Air Force medical officer in the United States Air Force from 1963-1973, retiring as a lieutenant

colonel, and

WHEREAS, Dr. Worrell continually expanded and enhanced his medical practice, beginning as an allergist-immunologist in 1973 and moving into the fields of environmental medicine in 1980 and nutritional biochemistry in 1984, and

WHEREAS, Dr. Worrell demonstrated his leadership abilities as past-president of the American Academy of Environmental Medicine, and

WHEREAS, Dr. Worrell was recognized for outstanding excellence in teaching within the field of Environmental Medicine by receiving the Herbert J. Rinkel Award, and

WHEREAS, Dr. Worrell shared his expertise with other health care professionals by serving on the board of trustees of Baptist Memorial Health Care System Inc. at Memphis, and

WHEREAS, Dr. Worrell

inspired thousands of medical students as an assistant clinical professor of pediatrics for the University of Arkansas College of Medicine at Little Rock; and

WHEREAS, Dr. Worrell inspired thousands of individuals in his own community as a public servant, presiding as a deacon and Sunday school teacher and playing an instrumental role in the development of a television ministry in Pine Bluff, and

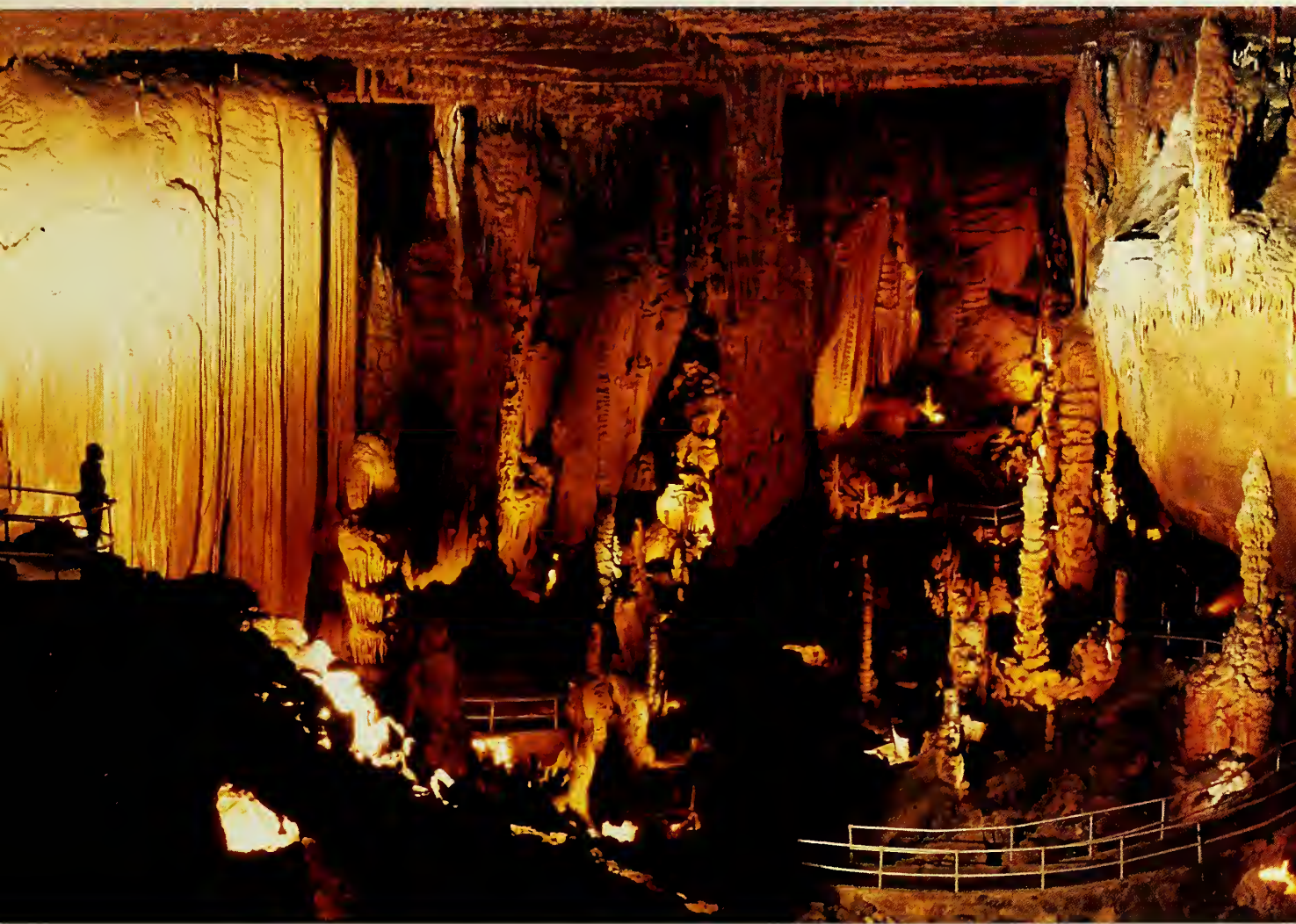
BE IT THEREFORE RESOLVED:

THAT, this resolution be adopted and placed in the archives of the Society; and

THAT, a copy be sent to Dr. Worrell's family as an expression of our sincere sorrow; and

THAT, a copy be made available to *The Journal of the Arkansas Medical Society* for publication.





## Blanchard Springs Caverns

For vacationers seeking seclusion, the Ozark Mountain region is a mecca that offers a bounty of intriguing outdoor attractions, such as Blanchard Springs Caverns.

For the first time, the National Forest System, which operates the park, will offer guided hikes into undeveloped sections of the caverns as part of its Wild Cave Tour. On the tour, visitors will crawl up and down slopes, squeeze through rooms with tight ceilings and scamper over boulders in a physically-demanding four-five hour tour. The highlight of the tour is a peek at the Titan Room, where a cluster of missile-shaped formations grow. The tours are available on Saturdays and Sundays. The cost is \$65 per person plus a non-refundable \$25 deposit. To make a reservation, call (888) 757-2246.

Two original trails — the Dripstone and the Discovery — lead visitors from room to room of sparkling flow stone, towering columns, delicate soda straw stalactites and beautiful crystalline formations. This living cave is only 15 miles northwest of Mountain View. The facility opens at 9 a.m. seven days a week during summer but is open five days a week from November-April. Guided tours begin at the

visitor center, and times vary for the last tour of the day.

As for overnight accommodations, choose from rustic-style camping in the Ozark National Forest, Victorian-style bed and breakfasts in Mountain View or Dry Creek Lodge on the grounds of Ozark Folk Center State Park. Dedicated to the preservation and perpetuation of traditional crafts and music, Ozark Folk Center offers crafts demonstrations, evening music programs and an on-premises restaurant that serves home-style cuisine. For information about Ozark Folk Center State Park, call (501) 269-3851. For reservations at Dry Creek Lodge, call (800) 264-FOLK.

For information about camp sites in the Ozark National Forest, call the state Department of Parks and Tourism, (800) NATURAL.

Country Oaks Bed and Breakfast in Mountain View caters to the adult traveler. A farm house and carriage house offer accommodations. For information, call (800) 455-2704.

The Inn at Mountain View, a beautifully restored Victorian home nestled in a quiet residential neighborhood, blends the best of the past and the present for a lodging experience you'll never forget. For information, call (800) 535-1301. ■



# ADVERTISERS INDEX

Air Force .....	113
Air Charter Express .....	131
AMS Benefits Inc. ....	Inside back cover
Arkansas Financial Group Inc., The .....	138
Arkansas Foundation for Medical Care .....	110
Arkansas Managed Care Organization .....	114
Asti, William Henry, AIA .....	113
Central Flying Service .....	126
Easter Seals .....	117
Flake and Kelley Management .....	112
Guesthouse Inn .....	127
HealthLink of Arkansas .....	130
Hoffman-Henry Insurance Corp. ....	134
Hutchinson/Ibrah Financial Services Inc. ....	121
Little Rock Medical Association .....	131
Maggio Law Firm .....	119
Medical Protective Co., The .....	108
Metropolitan National Bank .....	130
PhyAmerica Physician Services Inc. ....	127
Professionals Advocate Insurance Co. ....	Inside front cover
Regions Bank .....	126
Snell Prosthetic & Orthotic Laboratory .....	122
State Volunteer Mutual Insurance Co. ....	Back cover

Special Publications  
Publisher  
Brigette Williams

Special Publications  
Editor-in -Chief  
Natalie Gardner

Assistant Editor  
Christy L. Smith

Sales Manager  
Stephanie Hopkins

Account Executive  
Liz Earlywine

Director of Design &  
Circulation  
Virgeen Healey

Production and Circulation  
Coordinator  
Jeremy Henderson

Editorial Art Director  
Irene Forbes

Advertising Art Director  
Matt Stewart

Advertising Coordinator  
Kristen Heldenbrand

Marketing Assistant  
Mitzi Tffee

Database Administrator  
H.L. Moody



ARKANSAS BUSINESS  
PUBLISHING GROUP

Chairman and  
Chief Executive Officer  
Olivia Farrell

President and Publisher  
Jeff Hankins

Executive Vice President  
Sheila Palmer

© 2000 Arkansas Business  
Publishing Group  
www.abpg.com

Two of the best financial  
planners in the nation  
are in Arkansas.

They can be found at The Arkansas Financial Group.

**CINDY CONGER**  
MBA, CPA/PFS, CFP

**RICK ADKINS**  
MBA, CFP, ChFC



Since 1985,  
we've been  
helping busy  
people make  
smart financial  
decisions. So  
next time  
you're looking  
for objective  
answers to  
life's crucial  
financial deci-  
sions, call The  
Arkansas  
Financial  
Group. You'll  
be in great  
company.

Here's what the editors  
of *Worth* and *Medical  
Economics* had to say:

*"The Best 250 Financial  
Advisors, 9/99"*

*"The Best 300 Financial  
Advisors, 9/98"*

*"The Best 250 Financial  
Advisors, 10/97"*

*"The 120 Best Financial  
Advisors for Doctors, 7/27/98"*

*"Fee-only, objective, customized,  
comprehensive, affordable advice"*

**The Arkansas  
Financial Group, Inc.**  
**376-9051**

PHOTO: KELLY QUINN/TERRITORIAL RESTORATION



# Arkansas Medical Society Health Benefit Plan...



AMS BENEFITS, INC.

A wholly owned subsidiary of the  
Arkansas Medical Society  
P. O. Box 55088

Little Rock, Arkansas 72215-5088  
(501) 224-8967

WATS 1-800-542-1058

FAX (501) 224-6489

Ask about our other services including  
Professional Overhead, Disability  
& Life Insurance.

A black and white photograph of a doctor's office. On the left, a white lab coat hangs on a mannequin. In the center, a vintage sewing machine sits on a wooden table. To the right, a wooden chair is visible. The background features a framed picture of a group of people in period clothing.

***tailor-made for physicians***

The Arkansas Medical Society Health Benefit Program is a health insurance plan designed exclusively for members of the Arkansas Medical Society. Underwritten by American Investors Life Insurance Company. Indemnity and managed care plans available. For information call (501) 224-8967 or 1-800-542-1058.





*Guess who comes up short if your malpractice insurer doesn't quite measure up.*

**M**alpractice insurers are most definitely not created equal. And absolutely none are as wise, strong and fiscally fit as SVMIC. In fact, most others are just a little puny, in one way or another. With 25 years of experience in medical malpractice insurance, SVMIC is exactly the kind of company you want standing with you, when feeling ten feet tall is really most comforting. No excuses. No running for cover. Nothing else that we'd rather be doing. Malpractice insurance is our only business. As physicians, we at SVMIC truly understand what's at stake during potentially catastrophic litigation. After 25 years of standing tall, we're not about to back down now.



State Volunteer  
Mutual Insurance  
Company

For more information, contact Susan Decareaux or Thad DeHart • P.O. Box 1065 Brentwood, TN 37024-1065  
e-mail: [svmic@svmic.com](mailto:svmic@svmic.com) • Web Site: [www.svmic.com](http://www.svmic.com) • 1-800-342-2239 • (615) 377-1999



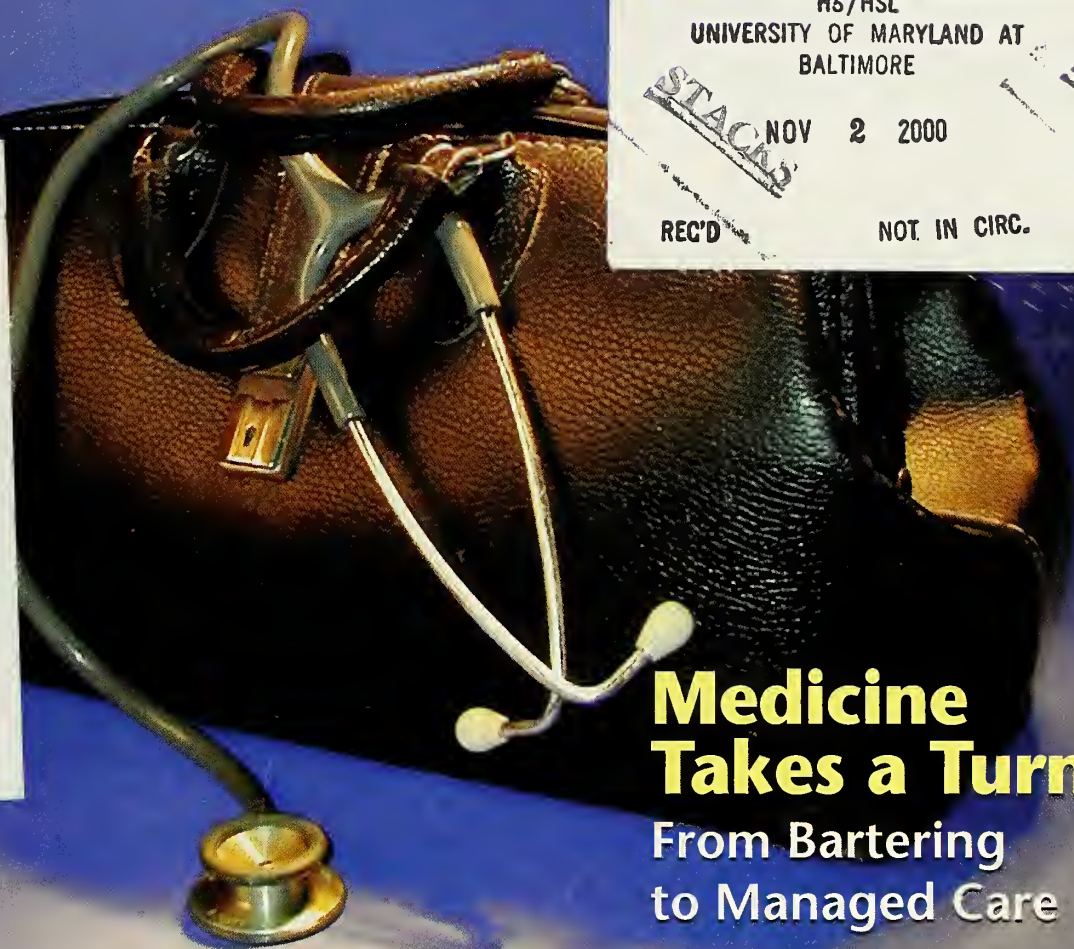


# THE Journal

OF THE ARKANSAS MEDICAL SOCIETY

Vol. 97 No. 5

November 2000



HS/HSL  
UNIVERSITY OF MARYLAND AT  
BALTIMORE

NOV 2 2000

REC'D

NOT IN CIRC.

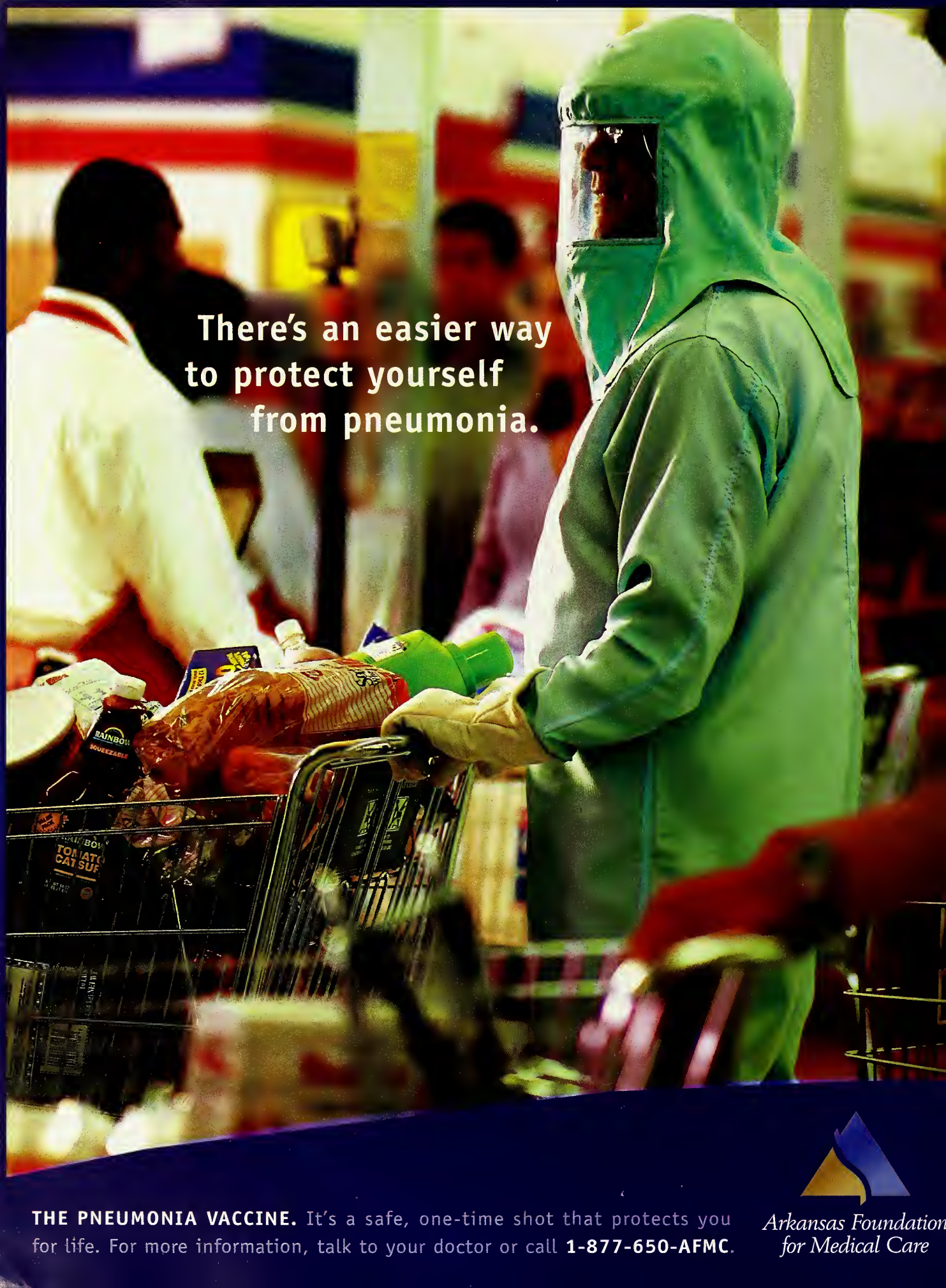
\*\*\*\*\*UNIMED ADC 64240  
S4 P2  
Health Sciences Library  
University of Maryland  
Acquisitions/Serials Dept.  
601 West Lombard St.  
Baltimore MD 21201

**Medicine  
Takes a Turn**  
From Bartering  
to Managed Care

# 1875-2000

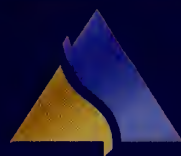
**Physicians Young and Old  
Share Their Memories**



A person wearing a full-body white protective suit, including a hood and a clear face shield, is pushing a metal shopping cart through a grocery store. The cart is filled with various items, including a large bag of bread, a green container, and several boxes of 'Rainbow' brand tomato catfish. In the background, other shoppers are visible, including a man in a white shirt and red apron. The scene is brightly lit, typical of a supermarket.

There's an easier way  
to protect yourself  
from pneumonia.

**THE PNEUMONIA VACCINE.** It's a safe, one-time shot that protects you for life. For more information, talk to your doctor or call **1-877-650-AFMC.**



*Arkansas Foundation  
for Medical Care*

# Get Published!

Give something back to your profession...

write an article for

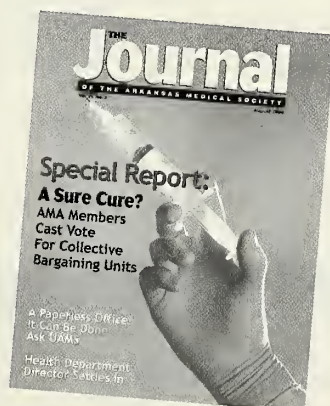
## **THE Journal** OF THE ARKANSAS MEDICAL SOCIETY

*The Journal* needs your thoughts and ideas.

So why not consider putting your expertise  
and experience on paper?

The Arkansas Medical Society is a statewide  
organization that represents all physicians,  
regardless of location or type of practice.

The result is a statewide network united for the  
common good of the medical profession. The staff  
of the Arkansas Medical Society provides members  
with the best information and services available.



For information about submitting an article to  
*The Journal of the Arkansas Medical Society*,  
call Judy Hicks at 501-224-8967  
or 1-800-542-1058.





There's nothing fair about treating physicians like fair game

**S**ome folks seem to think that taking pot shots at physicians is just good clean fun. We couldn't agree less. For 25 years, the physicians who operate SVMIC have dedicated themselves to providing the very best protection possible against medical malpractice litigation. As doctors, we know just how dangerous and unfair the world really can be. And, with our unrivaled risk management programs, no one can do more to prevent a physician from ever finding himself in the line of fire, than SVMIC.



State Volunteer  
Mutual Insurance  
Company

For more information, contact Susan Decareaux or Thad DeHart • P.O. Box 1065 Brentwood, TN 37024-1065  
e-mail: [svmic@svmic.com](mailto:svmic@svmic.com) • Web Site: [www.svmic.com](http://www.svmic.com) • 1-800-342-2239 • (615) 377-1999

## CONTENTS

### FEATURES

#### 154 Celebrating 125 Years

*The Arkansas Medical Society and the physicians it serves have drastically changed over the past 125 years. Medicine has gone from the bartering system to managed care, and training of physicians has increased more and more.*

#### 156 The Young and Old

*Dr. John Jones of Texarkana is AMS' oldest member, while Dr. Cheryll Rich of Corning is the society's youngest practicing physician. Both have unique perspectives on practicing medicine in Arkansas.*

#### 164 Quality Improvement Programs Depend on Team Work

*Over the past several years, the department of family and community medicine at the University of Arkansas for Medical Sciences has experimented with ways to incorporate quality improvement strategies into the family practice clinical setting. Here, researchers give a report on their findings.*

### DEPARTMENTS

149 Commentary  
*Joseph Beck, MD*

151 Letter to the Editor

153 What We've Done  
For You Lately

160 Cardiology Report

170 People + Events

173 Index to Advertisers

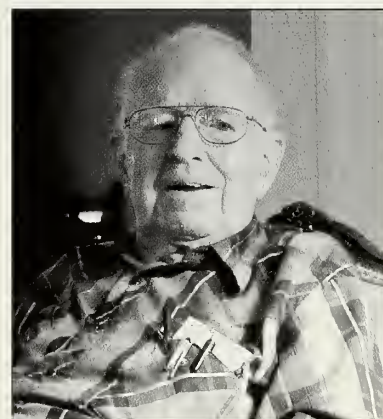
174 Arkansas Retreats

**On the cover:** The doctor's bag and stethoscope on the cover was provided by Dr. Samuel B. Welch of Little Rock.

Photo: Kirk Jordan



*The practice of medicine has come a long way since the Territorial Days.*  
— page 154



*Dr. John Jones of Texarkana reminisces about his 55 years in practice.*  
— page 156



There's a simple way  
to determine the value  
of your malpractice insurance.

# Get sued.

We said it was simple. We didn't say it was a lot of fun. But you get what you pay for. And with Medical Protective you're paying for a company that wins 90% of its cases that go to trial with a vast majority closing with no payment. You're paying for coverage that fits your needs and a policy that leaves the final decision to settle in your hands.\*

You're also paying for something else - peace of mind. A peace of mind that was recently strengthened when The Medical Protective Company became a part of Employers Reinsurance Corporation, a GE Capital Services company. This union solidifies our absolute commitment to the protection of doctors like you. If your most valuable asset, your reputation, is on the line, protect yourself with our unparalleled defense strategy. Nearly 60,000 of your colleagues do. For the Medical Protective representative in your area, call (800) 344-1899.

[www.medicalprotective.com](http://www.medicalprotective.com)



**The Medical Protective Company®**

\*Unless prohibited by law.



COMMUNICATIONS COORDINATOR  
Judy Hicks

EXECUTIVE VICE PRESIDENT  
Kenneth LaMastus, CAE

ASSISTANT EXECUTIVE VICE PRESIDENT  
David Wroten

#### EDITORIAL BOARD

Jerry Byrum, MD	Pediatrics
Joseph M. Beck, II, MD	Oncology
Lee Abel, MD	Internal Medicine
Samuel Landrum, MD	Surgery
Jerry Kendall, MD	Family Practice
William Ackerman, MD	Anesthesiology

EDITOR EMERITUS  
Alfred Kahn Jr., MD

#### ARKANSAS MEDICAL SOCIETY 2000-2001 OFFICERS

Gerald A. Stolz, Jr., MD, Russellville  
*President*

Joe Stallings, MD, Jonesboro  
*President-elect*

Paul A. Wallick, MD, Monticello  
*Vice President*

Lloyd G. Langston, MD, Pine Bluff  
*Immediate Past President*

Carlton L. Chambers, III, MD, Harrison/Little Rock  
*Secretary*

Dwight M. Williams, MD, Paragould  
*Treasurer*

Anna Redman, MD, Pine Bluff  
*Speaker, House of Delegates*

Kevin Beavers, MD, Russellville  
*Vice Speaker, House of Delegates*

Joseph M. Beck, II, MD, Little Rock  
*Chairman of the Council*

Established 1890. Owned and edited by the Arkansas Medical Society and published under the direction of the Council.

**Advertising Information:** Contact Stephanie Hopkins, P.O. Box 3686, Little Rock, AR 72203; (501) 372-2816.

**Postmaster:** Send address changes to: *The Journal of the Arkansas Medical Society*, P. O. Box 55088, Little Rock, Arkansas 72215-5088.

**Subscription rate:** \$30.00 annually for domestic; \$40.00, foreign. Single issue \$3.00.

*The Journal of the Arkansas Medical Society* (ISSN 0004-1858) is published monthly by the Arkansas Medical Society, #10 Corporate Hill Drive, Suite 300, Little Rock, Arkansas 72205. Printed by The Ovid Bell Press, Inc., Fulton, Missouri 65251. Periodicals postage is paid at Little Rock, Arkansas, and at additional mailing offices.

Articles and advertisements published in *The Journal* are for the interest of its readers and do not represent the official position or endorsement of *The Journal* or the Arkansas Medical Society. *The Journal* reserves the right to make the final decision on all content and advertisements.

Copyright 2000 by the Arkansas Medical Society.



**ROLEX**

OYSTER PERPETUAL  
**LADY DATEJUST**

CHRONOMETER IN STEEL AND 18 KT. GOLD.  
OR 18 KT. GOLD. FLUTED BEZEL.  
PRESSURE-PROOF TO 330 FEET /100M.

*Official Rolex Jeweler*  
**MARY HEALEY'S**  
FINE JEWELRY

*Because You Love the Best*  
5600 Kavanaugh • 501-661-1314

Rolex, O, Oyster, Oyster Perpetual and Datejust are trademarks.

We offer everything the huge brokerage houses offer, minus the huge part.

Metropolitan Investment Professionals is an investment alternative to the big impersonal brokerage houses. We offer the same products and services, but with the personal attention you need and deserve. We're conveniently located in Metropolitan's Financial Centre and McCain branches.

So whether it's financial planning, stock trading, retirement planning, 401K rollovers, life insurance services or variable annuities that you need, try Metropolitan Investment Professionals.

Call Charles Jackson at 221-7213 or Delores Carroll at 753-3785.



**Metropolitan**  
**Investment Professionals**  
Securities Offered Through Investment Professionals, Inc.

Member NASD and SIPC

The products offered are not FDIC insured. Products are not deposits or other obligations or guarantees of the bank and are subject to investment risks, including the possible loss of principal amount invested.





## FARMERS

HEALTHCARE PROFESSIONAL LIABILITY

### *Farmers® Financial Strength*

Three independent organizations rated Farmers on our overall financial picture, the strength of our management, financial reserves, policy types and claims-paying history.

A.M. Best rating of A+ (superior)

Standard and Poors rating of AA+

Moody's Investors Service rating of Aa3 (excellent)

We've been insuring healthcare providers for almost 50 years — protecting you against the unknown and unplanned.

*You're the best at  
what you do  
...so are we.*

## You Know Our Name

For 72 years, Farmers has been a leader in the insurance industry. Farmers is no newcomer to **Arkansas**. Many of you have your homes and autos insured by Farmers.

### **But, Did You Know?**

For almost 50 years, Farmers Healthcare Professional Liability has specialized in providing coverage and risk management solutions to the changing liability risks associated with the delivery of healthcare. These virtues are reflected in our underwriting practices, claims management, risk management and education services and actuarial principles.

### **A Name You Can Trust**

The face of healthcare changes daily, exposing you to new liability risks that you don't even know exist. At Farmers, we know how to protect physicians against known and unknown exposures, so you don't get caught unaware or underinsured.

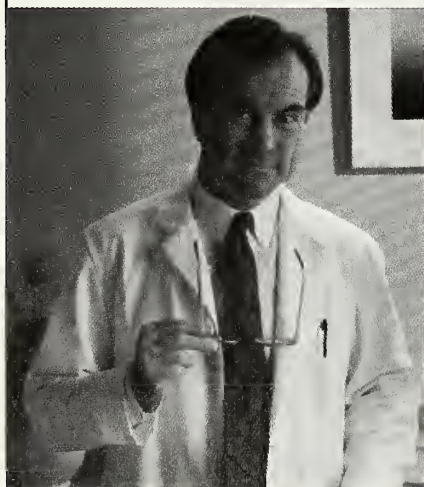
*We know our business.*

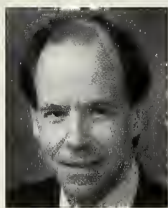
Farmers' Healthcare Professional Liability team has an extensive background in medical services and management. Our **experience** makes us the best at what we do. It enables us to offer a spectrum of services, including:

- *Vigorous Defense of Claims*
- *Superior Risk Management Service*
- *Experienced Underwriting*
- *Assertive Claims Handling*
- *Discounts*
- *Flexible Limits*

Farmers has the expertise you can trust to get you back where you belong — delivering quality medical care. For more information on Farmers Healthcare Professional Liability coverage, call

**Jack Pyle, Sales Director**  
**(501) 312-2206**





# Advocate Fatigue

JOSEPH M. BECK, II, MD, FACP

**M**ore and more lately, I've developed a profound fatigue relating to certain aspects of my job as a medical oncologist. I still love the science, challenge and the gratifying effects the treatments can sometimes produce. These things are exhilarating. I've come to call my particular type of fatigue "advocate fatigue."

There are many patient advocates. Each nurse, pharmacist, physical therapist and even hospital administrator purports to be a patient advocate — and many succeed. However, no one but the physician sees the patient regularly over months or years. No one but the physician takes a hallowed oath to ALWAYS do what is best for the patient (no mention of cost of treatment in the oath I took or of saving money for the insurance company stockholders). I swore that oath seriously and permanently. And so, as medicine has evolved, so has my practice of it. Prescribing habits, hospitalization indications, chemotherapy protocols are all vastly different today than when I trained 15 years ago.

What has remained exactly the same is the sick person in the bed depending on my care and knowledge. What has remained exactly the same is the fact that the physician bears the ultimate moral and legal responsibility for what happens to the patients under his or her care, despite budget cuts, layoffs, pool nursing or health maintenance organizations' medical practices. What has remained exactly the same is that while physician judgment concerning patient care issues is questionable and open to debate by allied personnel during business hours, that same judgment is sacrosanct at night, on weekends and holidays — and in court.

And so, as I make my daily journey on hospital rounds, I find that many things that once happened routinely because I wrote an order (not a suggestion or request) now occur sluggishly or not at all. Since the patients are still sick and need to be cared for, this added responsibility falls not on the hospital administrator or the physi-

cal therapist or even nursing personnel — whose shifts end at preset times no matter how dire the situation or how sick the patient — but on the ultimate patient advocate, the physician. Critical labs are not called, despite repeated requests, and ordered labs are not done. The call lights, unanswered, are ignored.

One would think that problems as serious as these would be quickly and effectively acted upon by administrative and nursing personnel if only they were brought to the attention of the individuals in charge. Think again. These problems occur on a daily basis and are reported frequently. Yellow pads are produced, lists are generated, promises are made and grand statements about quality care, partnering, outcomes and correct nursing matrix fly about, but nothing changes. Thoughtful physicians, attempting to take seriously their oath, prescribe the best drugs for a particular condition, only to be told by the pharmacist (who bears no ultimate responsibility for the patient) that the drug in question is not on formulary due to the expense and that a different, possibly less effective or more toxic medication, will be used. Patients are forced to bring their own medications into a tertiary care medical center, and if they want to receive them on time and correctly, they or their families administer them.

And so I have advocate fatigue. I love being a doctor and enjoy taking care of my patients, so I'll keep making phone calls and begging ancillary personnel to please do the job they are being paid to do and reporting deficiencies to the appropriate people. But I'm tired. And other excellent physicians that I am honored to practice with are tired. But we took that oath seriously, and our patients have no one else, really, but us. ■

*Dr. Beck is an oncologist in Little Rock, chairman of the AMS Council and a member of the editorial board for The Journal of the Arkansas Medical Society.*

## ST. VINCENT HEALTH SYSTEM

### Hospitalist Opportunity

Actively searching for internist interested in serving in the exciting new specialty of full time hospital care. If you have a interest or know someone interested in a hospitalist role, please contact Faye G. Stewart at St. Vincent Health System 501-660-3245 or 800-482-1288 ext. 3245.

† CATHOLIC HEALTH INITIATIVES

**St. Vincent Health System**

INTENSIVE CARING.

[www.stvincenthealth.com](http://www.stvincenthealth.com)

## ARCHITECTURE

FOR YOUR MEDICAL NEEDS

1 800 764 ASTI



**William Henry Asti, AIA**  
architects, economists, development consultants



**Two of the best financial planners in the nation are in Arkansas.**

**They can be found at The Arkansas Financial Group.**



Since 1985, we've been helping busy people make smart financial decisions. So next time you're looking for objective answers to life's crucial financial decisions, call The Arkansas Financial Group. You'll be in great company.

Here's what the editors of *Worth* and *Medical Economics* had to say:

*"The Best 150 Financial Advisers for Doctors, 8/00"*

*"The Best 250 Financial Advisers, 9/99"*

*"The Best 300 Financial Advisers, 9/98"*

*"The Best 250 Financial Advisers, 10/97"*

*"The 120 Best Financial Advisers for Doctors, 7/27/98"*

*"Fee-only, objective, customized, comprehensive, affordable advice"*

**The Arkansas  
Financial Group, Inc.  
376-9051**

**CINDY CONGER**  
MBA, CPA/PFS, CFP

**RICK ADKINS**  
MBA, CFP, ChFC

PHOTO: KELLY QUINN/TERRITORIAL RESTORATION

**Central Arkansas Hospital, Searcy, AR**

- ✓ BC EM or PC physicians.
- ✓ ACLS, ATLS, PALS required.
- ✓ Directorship opportunity also available.
- ✓ Annual volume: 9,000.
- ✓ Located near Greers Ferry Lake.

**Lawrence Memorial Hospital, Walnut Ridge, AR**

- ✓ BC/BP physicians & 3rd year residents w/EM or PC specialty—ACLS required.
- ✓ Annual volume: 7,500.
- ✓ 1 hour northwest of Memphis, TN.

**Cross Ridge Community Hospital, Wynne, AR**

- ✓ BC/BP EM or PC physicians—ACLS required.
- ✓ Annual volume: 6,300.
- ✓ 30 minutes south of Jonesboro, AR.

**Baptist Medical Center, Heber Springs, AR**

- ✓ BC/BP EM or PC physicians—ACLS required.
- ✓ Annual volume: 6,500.
- ✓ Beautiful historic town, rolling hills, on Greers Ferry Lake.



**PhyAmerica**  
Physician Services, Inc.

**THERE'S SOMETHING FOR  
EVERYONE IN ARKANSAS**  
—The Natural State—

For information on these and other Arkansas opportunities, contact:

**Traci Mahlmeister,  
Physician Recruiter**

2828 Croasdaile Drive  
Durham, NC 27705

Phone: 800-476-5986

Fax: 919-382-3274

tmahlmei@phyamerica.com

www.phyamerica.com

*All inquiries confidential.*

# LETTERS

June 12, 2000

Dr. J. David Talley  
UAMS Department of Cardiology

Dear Sir:

I am writing this letter to you because of a recent literature search I did on the issue of peripartum cardiomyopathy. I noted a short review article on this subject which you co-authored, that was in *The Journal of the Arkansas Medical Society* in October 1998.

I practice internal medicine and noninvasive cardiology here in El Dorado and do most of the echocardiograms. In the past five months I have done echocardiograms on five ladies — having seen three of them in consultation — who all meet the standard criteria for diagnosis peripartum cardiomyopathy. We have had 279 deliveries during that time. This calculates to an incidence of one case in every 55.8 deliveries. This represents a remarkable increase in the reported incidences, which you quote in your article as being between 1,300 and 15,000. Because of this I have initiated an extensive chart review on these patients and have contacted the Arkansas State Health Department and the Center for Disease Control in Atlanta. I am hoping to conduct further investigation and enlist the assistance of the CDC. I thought you might be interested in this information, and certainly I would appreciate any comments or thoughts you might have on the subject. ■

Sincerely yours,

Alvin Scott Hardin, MD

## Correction

In the Women in Medicine issue, September 2000, it was incorrectly reported that there was one female graduate in the University of Arkansas for Medical Sciences Class of 1980. Twenty-two women graduated with the class.

*What you pay for.*



*What you get.*



For more information about what **SKYSHARE** can mean to you call Cheri McKelvey at 375-3245 x321  
**Central Flying Service, Inc.**

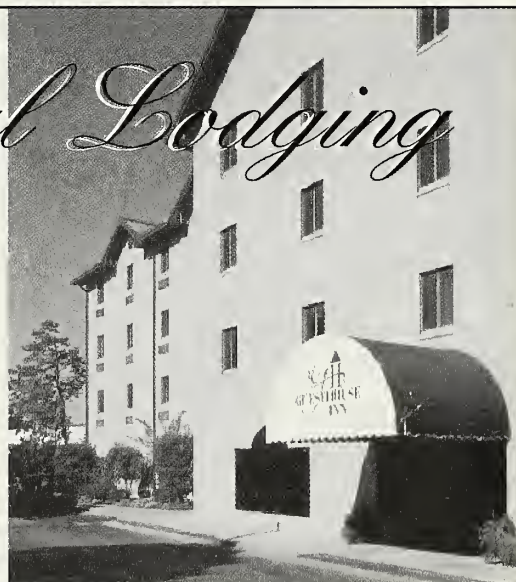
## Medical Lodging

Close proximity to all  
Little Rock hospitals

Serving Little Rock Visitors

- Medical stays
- Business travel
- Leisure travel

"Guesthouse Inn is your  
perfect home away from home  
while in Little Rock"



**GH**  
**GUESTHOUSE**  
Inns • Hotels • Suites

301 So. UNIVERSITY AVE. ▲ LITTLE ROCK, AR 72205 ▲ (501) 664-6800



# Arkansas Medical Society Health Benefit Plan...



## AMS BENEFITS, INC.

A wholly owned subsidiary of the  
Arkansas Medical Society

P. O. Box 55088

Little Rock, Arkansas 72215-5088

(501) 224-8967

WATS 1-800-542-1058

FAX (501) 224-6489

Ask about our other services including  
Professional Overhead, Disability  
& Life Insurance.

*tailor-made for physicians*

The Arkansas Medical Society Health Benefit Program is a health insurance plan designed exclusively for members of the Arkansas Medical Society. Underwritten by American Investors Life Insurance Company. Indemnity and managed care plans available. For information call (501) 224-8967 or 1-800-542-1058.





## AMS' Political Message Stays the Same

By Z. LYNN ZENO  
DIRECTOR OF GOVERNMENTAL AFFAIRS

**U**nder the heading "what we've we done for you lately" the term *lately* can be relative. One of the things the Arkansas Medical Society has done lately for its members is the same service that we have been providing for the past 125 years. As the AMS prepared to celebrate our 125th year of service with this special issue, we reviewed documents and past *Journals* dating back to our origination in 1875. One of the recurring topics of discussion was the need to travel to the state's Capitol and meet with the "Representatives of the People" to discuss issues relating to public health.

In his 1880 address before the Fifth Annual Session, AMS President Dr. E. T. Dale told his colleagues, "It is time that the profession should take a more prominent role in public affairs, be more interested workers for and promoters of public legislation. It is the duty of physicians, as citizens, to see that the interests of state medicine are cared for." That year the AMS lobbied the Legislature for the creation of a Board of Health (to address the yellow fever epidemic) and a State Lunatic Asylum. THE MESSAGE AND ITS IMPORTANCE HAS NOT CHANGED! The only difference is that today the topics have progressed, or maybe digressed, to issues such as tort reform, AIDS, Internet medicine and the encroachment of third-party payers upon a physician's provision of patient care.

As we celebrate our 125th year, the Arkansas Medical Society will continue to be the leading advocate for Arkansas patients and physicians. As the director of governmental affairs, I will continue to lobby and monitor the state and national legislatures. However, our success ratio vastly improves when every member physician, their families and their office staffs becomes actively involved in the process.

Within a few days, on Oct. 29 at the Embassy Suites Hotel in Little Rock, the AMS will hold its biennial fall meeting to discuss the upcoming 2001 legislative session. This outstanding program will feature a review of anticipated medical issues to be considered by the Arkansas General Assembly; a presentation on using the Internet for grassroots communication with state and federal legislators; and a special session entitled "Politics, Power & You," presented by nationally known political consultant Michael E. Dunn of Washington, D.C. If you have not registered for this special meeting, please call the AMS office, (800) 542-1058, or 224-8967 if you're in Little Rock, and sign up today. ■

*The message today is the same as it was in 1875. IF YOU DON'T TAKE PART...YOU'LL GET TAKEN APART. Get involved in the legislative process today!*

# Need to Brag?

Let your peers  
& colleagues  
know:  
**Top Flight  
Hospital  
Services,  
New Hires  
& Associates,  
Promotions,  
Honors &  
Awards.**

**THE  
Journal**  
OF THE ARKANSAS MEDICAL SOCIETY

**For Advertising Information,  
Contact Stephanie Hopkins  
501-372-2816 ext. 293.**



# From Bartering to Managed Care

*Medicine Has Drastically Changed Over the Past 125 Years*

*By Christy L. Smith*

ARKANSAS' PHYSICIANS HAVE ALWAYS FACED CHALLENGES — FROM MEDICINE BAGS minimally equipped with ipecac, opium and a lancet to managed care. To commemorate the Arkansas Medical Society's 125th birthday, we offer a brief history of the state's medical profession.

Today's physicians must endure extensive and rigorous medical school training in order to receive a license to practice, but that wasn't always the case. Prior to the 20th century, a man had only complete an apprenticeship to practice medicine, Dr. William P. Scarlett wrote in the August 1892 *Journal*.

The first law regulating physician licensing was not passed until 1881. Neither a medical degree nor literacy was a requirement for licensure, which angered members of the Arkansas Medical Society. The society activated its Committee on Medical Legislation in 1892 to draft more acceptable licensing laws, "the one most effective action ever taken by our society to protect the welfare of the people and the physicians of this state," Dr. Watson said.

Even still, students with only a high school diploma were being admitted to the state's medical school until 1910, according to a time line prepared by Edwina Walls Mann, former head of UAMS' history of medical department.

## Medical School Evolves

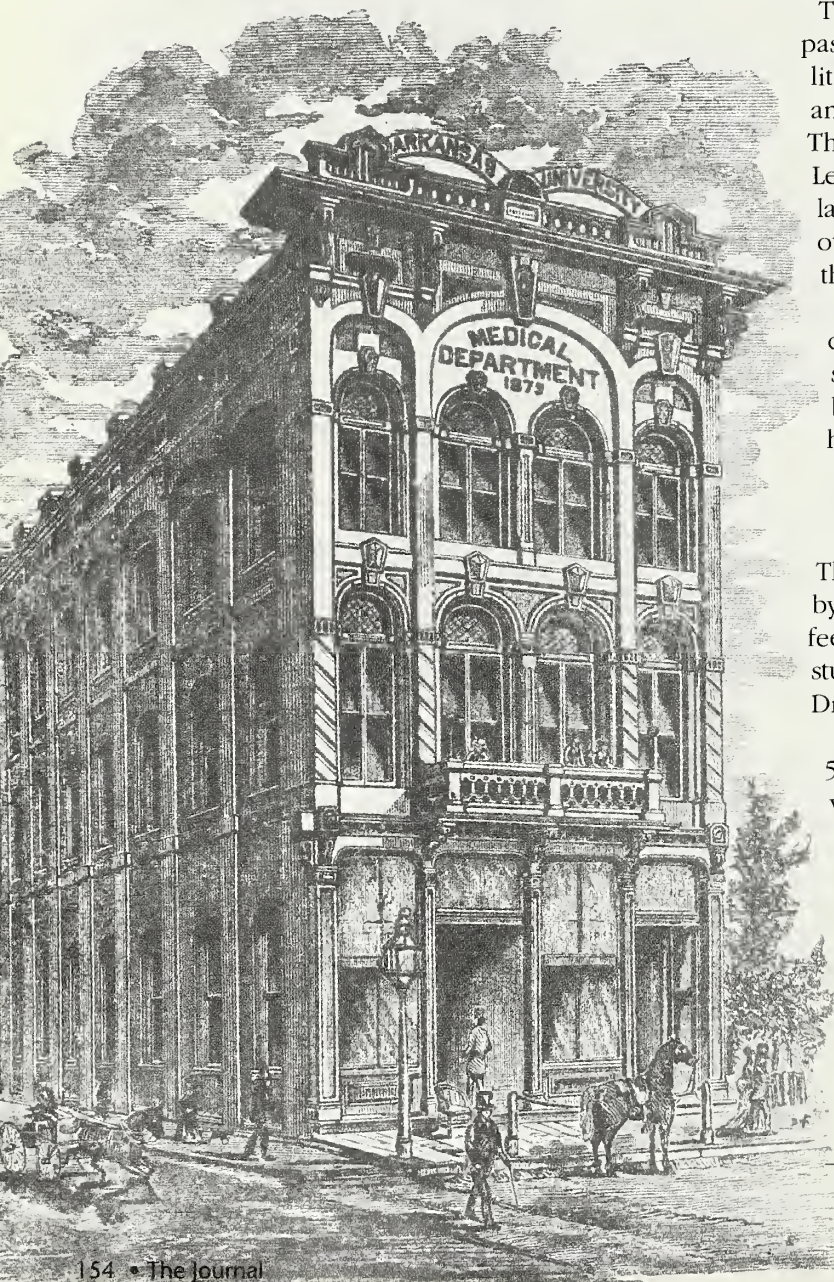
UAMS itself has enjoyed an exciting existence. The state's first medical school was founded in 1874 by eight doctors. It was funded entirely by student fees and contributions, and none of the first 20 students were required to take an entrance exam, Dr. Watson noted.

The medical school's enrollment may be nearly 50% women today, but in 1935 only 12 women were enrolled at UAMS, said Dr. Agnes J. Carpenter Kolb in a 1995 interview.

"There were six in my class ... We had three of our professors tell us ... 'This is no place for you women,'" she said.

In 1948, UAMS admitted its first black student, a woman named Edith Irby, Mann said.

Thirty-seven percent, or 55 out of 150, of the fall 2000 enrollment was women, said Tom South, UAMS' director of admission. And many recent



*UAMS opened its doors in 1879 at 113 W. Second St. in Little Rock.*





*The state Medical Society held its 36th annual session in 1912 in Hot Springs.*

graduates report they were accepted at the school with open arms.

### Changing Medical Issues

The practice of medicine also has changed drastically in Arkansas. As late as 1918, Arkansas physicians were contending with epidemics of influenza, Mann recorded.

By this time, morphine and Epsom salts had found their way into a doctor's medical bag. But unfortunately the use of morphine "made morphine addicts out of many patients," Dr. Scarlett wrote in the August 1982 *Journal*.

When Dr. Scarlett began practicing medicine in 1925, surgical procedures were still rather crude and the number of specialists was limited, he wrote. Dr. Scarlett noted that the first heart surgery was not performed until World War I.

"Now surgeons do all manner of operations on the heart," he wrote.

Dr. Scarlett also expressed amazement at the number of specialists practicing across the state. In 1925, there was only one urology surgeon, one lung specialist and no orthopedic surgeons, he wrote. In 1982, Dr. Scarlett said there were 784 physicians and "41 types of specialists" listed in the Little Rock telephone directory.

Today, there are 58 different specialties and well more than 784 individual physicians and surgeons listed in the telephone directory.

In fall 1973, the state's first Arkansas Area Health Education Center was created in Pine Bluff, according to an article in the October 1993 *Journal*.

Begun as a way to supply family physicians to rural areas, the agency has evolved into a six-center health education network providing direct health care to residents and a mini-medical center providing health education to health profession students, the authors noted.

In the last 25 years, the medical community has begun dealing with managed care. Many physicians are retiring early because their time is now spent on paperwork rather than patient care.

Interestingly enough, managed care wasn't even a glimmer in the eye of insurance peddlers before 1949, when Blue Cross was established. During the Depression, patients did not have insurance or Medicare to rely on, Dr. Scarlett wrote. But none were turned away by the physician, he said.

"We doctors did about as much or more charity [cases] as pay cases during the Depression," said Dr. Scarlett.

The Arkansas Medical Society has played an important role in keeping physicians informed about issues such as managed care. But it is interesting to note that physicians did not begin organizing themselves into professional groups until 1845, when the first local medical society was established, Dr. Watson noted.

The Arkansas Medical Society as we know it today was established in 1875 with 225 members. And since its creation, the organization has remained steadfast in its role as an advocate for Arkansas' physicians. ■

## AMS' Journal Has Taken on a More Sophisticated Look

Since it debuted in April 1880, *The Journal of the Arkansas Medical Society* has provided physicians with information on diseases and laws.

The first issue featured an article by Dr. T.E. Murrell, who offered advice on extracting foreign objects from patients' ear canals.

Buttons, seeds, stones, grains of corn, paper wads, houseflies and spiders often found their way into the ear canal, Dr. Murrell wrote.

While most cases could be treated with a squirt of warm water, extreme measures such as "turning the ear down and jarring the head" were sometimes used, he said.

Advertising found its way into the publication in June 1906.

The first ad to appear in *The Journal* was placed by Detroit-based Parke Davis Co., peddlers of acetozone, an intestinal antiseptic used to treat typhoid fever, diarrhea, dysentery and cholera.

In September 1943, Camel asked *Journal* readers to send cigarettes to American servicemen. At the same time, the *Journal* made an appeal to its members younger than 45 to sign up for military duty.

"The need is so positive that the questions of essentiality of men in positions of teaching and research and in industrial medicine are likely to be rigidly reviewed," an editorialist wrote.

By June 1955, about 45 of *The Journal's* 68 pages were devoted to advertising. Of course, *The Journal* now devotes more space to editorial, and the publication's appearance has changed, as a result.

*The Journal's* generic covers gave way to glossy photographed covers in the late 1990s, and articles on managed care and women physicians have replaced Dr. Murrell's now-humorous look at ear canals.



# Managed Care Rarely Touched This Physician's Life

By Christy L. Smith

**D**R. JOHN W. JONES OF TEXARKANA NEVER QUESTIONED HIS LIFE'S CALLING. "I found out a long time ago that the happiest spot is in the OB waiting room. When you put pregnant women with other pregnant women, they laugh, and they joke with one another. Pregnant women are a jolly bunch to be around," he said.

The 93-year-old retired obstetrician and gynecologist delivered his first baby in 1932. He is the oldest member of the Arkansas Medical Society.

Dr. Jones' career spanned 55 years, during which his main focus was always medicine. His wife, Mary Jane, raised the children while her husband saw patients and accepted emergency calls into the wee hours of the night. In that day, Dr. Jones said, they expected no less.

"That was just part of it. I knew what it was going to be like to be married to a doctor," said Mary Jane Jones, a former registered nurse.

Dr. Jones was born in 1907 on a stock farm near Hallsville, Mo. He said his physician uncle tried to steer him toward a career in dentistry because medicine demands so much of a physician's time.

"He tried to tell me that I

really didn't want to be a doctor because your time is always somebody else's. But I didn't mind that," Dr. Jones said.

In 1924, Dr. Jones enrolled at the University of Missouri at Columbia, about 12 miles away from his home. He lived on the farm and drove his Ford roadster to and from class along the dirt and gravel roads between Hallsville and Columbia. He was a student assistant at the university and a member of Phi Beta Kappa honor society. After graduation, he attended the University of Missouri medical school for two years before transferring to Washington University in St. Louis.

In 1933, Dr. Jones moved to Detroit for a surgical internship at Henry Ford Hospital. He said he sometimes was on call every other night.

A residency in obstetrics and gynecology was next on Dr. Jones' agenda. He began the residency at Henry Ford but did a one-year rotation at Duke

University, traveling with three medical students to impoverished areas of North Carolina to deliver babies in people's homes.

"Students could not sign birth certificates, and so I supervised the students and signed all the birth certificates," he said.

*Continued on Page 158*



# Rural Physician Represents New Face of Medicine

*By Christy L. Smith*

**D**R. CHERYLL RICH IS SOMEWHAT OF A CURIOSITY TO THE 3,000 RESIDENTS OF Corning, where she practices family medicine at the Family Medical Center.

The 28-year-old physician is the only female doctor within a 30-mile radius, and she works while her husband stays at home with the children. But the youngest practicing physician of the Arkansas Medical Society laughs off the stares. She understands that, for many people, she represents a new face of medicine.

"In the beginning, most of the patients who scheduled an appointment with me did it to get a look at the new young, lady doctor. I've gotten used to it. Still yet, I am referred to as the lady doctor," she said.

## Dr. Cheryll Rich

The oldest of three children, Dr. Rich was raised in

Neelyville, Mo., 10 miles north of Corning. She

doesn't remember a time when she didn't want to be a doctor.

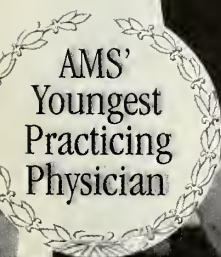
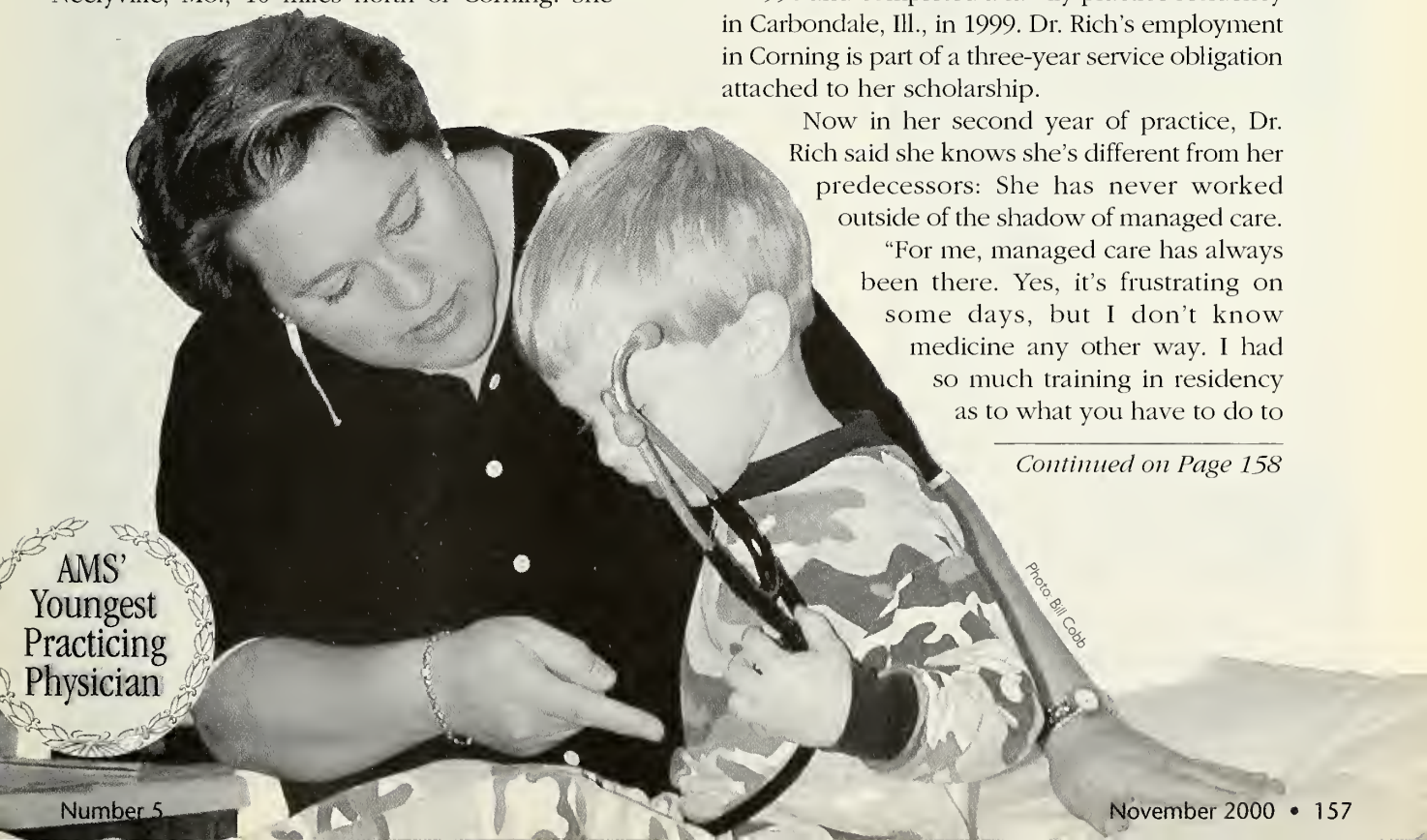
"I had a sick grandmother, and that just kind of always stuck with me. I don't remember ever wanting to be anything else," she said.

Dr. Rich received a National Health Service Corps scholarship to attend medical school at the University of Missouri, Kansas City. She graduated in 1996 and completed a family practice residency in Carbondale, Ill., in 1999. Dr. Rich's employment in Corning is part of a three-year service obligation attached to her scholarship.

Now in her second year of practice, Dr. Rich said she knows she's different from her predecessors: She has never worked outside of the shadow of managed care.

"For me, managed care has always been there. Yes, it's frustrating on some days, but I don't know medicine any other way. I had so much training in residency as to what you have to do to

*Continued on Page 158*





## Dr. Jones

*Continued From Page 156*

While at Duke, Dr. Jones learned about a doctor who was building a new clinic in Texarkana. He worked as house physician at Parkland Hospital in Dallas until accepting an OB/GYN post at Southern Clinic in Texarkana in 1939. He also joined the Arkansas Medical Society that year.

Three years later, Dr. Jones found himself part of the 1st Auxiliary Surgical Group in the European Theater during World War II. Based at a hospital near South Hampton, England, Dr. Jones was part of a seven-member team that traveled across Europe tending to wounded soldiers.

"Most times we had a vehicle, and we would travel from place to place at a moment's notice," he said.

The small-town boy from Missouri lived the history that many only read about in textbooks. He crossed the bridge at Remagen, Germany, the only

bridge across the Rhine River left standing by the Nazis; he cared for some of the first casualties from the Battle of Normandy; and he saw British Prime Minister Winston Churchill speak on several occasions, experiences that left a lasting impression.

"Whenever Churchill was speaking, you wanted to listen. Old Churchill had a wonderful voice ... He could just buy you out [with his speeches]," Dr. Jones said.

Dr. Jones returned to Texarkana following the Japanese surrender in 1945. At Southern Clinic, he met his future wife, a hometown girl who's first husband had been killed during the war. The two married in 1947 and have two daughters and three grandchildren.

Dr. Jones continued taking call duty until 1984, when he was 77 years old. He gave up most of his OB/GYN patients in 1985, and then finally retired three years later at the

age of 80. He said he always knew he would work until he could work no longer; early retirement was never an option in his book.

"No, I never questioned that. [But] my uncle told me, 'You better get out before you are thrown out.' That stuck with me. You know when you can no longer practice. I would get so tired sometimes standing around the operating table," he said.

Dr. Jones said he misses the doctor/patient relationships he's established over the years. He's glad he never really had to deal with the headaches of managed care, and the biggest change he saw during his career was the increased availability of prenatal care, he said.

Dr. Jones estimated that he delivered 250-300 babies every year during his career. At that rate, Dr. Jones has delivered about 14,000 babies in his lifetime, an observation that doesn't even make him blink an eye. ■

## Dr. Rich

*Continued From Page 157*

get paid [or] for them not to hassle you. That was as much of my training as hands-on with patients. It's almost second nature," she said.

Another noticeable difference, Dr. Rich refuses to place her family second to her career, as so many of her predecessors did.

"This is not my life; this is my job. I really like my job, and I take it very seriously, but I'm not a doctor No. 1. I'm a mother; I'm a wife. And somewhere down the line [medicine] falls," Dr. Rich said.

Dr. Rich is 30 years younger than the most junior of her three colleagues. All four are salaried employees who generally work eight hours a day, five days a week. None have call duty because the local hospital closed nearly a decade ago.

The relatively relaxed work schedule allows Dr. Rich to spend more time with her family. Even still, her husband, Jerry, who has a teaching degree, has opted to remain at home with Lauren, 4, and Jacob, 22 months, until the children reach school age.

"It's good when one parent can stay at home, and he was really happy to do that. As a teacher, he would make about \$20,000 a year. By the time you pay \$12,000 a year for day care, it was a no-brainer," Dr. Rich said.

The bulk of the nearly 3,000 patients who go to Family Medical Center are Medicare or sliding-fee patients, and Dr. Rich focuses much of her time on women's and adolescent health.

The clinic also serves as a make-shift emergency room during working hours. It isn't unusual for a minor fracture, cut or chest pain to interrupt the normal schedule. But after dark, things are pretty quiet for Corning's four physicians, Dr. Rich said.

"Because the hospital [in Corning] has been closed for so long, people are used to calling one of the nearby emergency rooms [in Poplar Bluff, Paragould or Jonesboro] if something happens after hours. Most of them wait until 8 in the morning when the clinic opens, if they can," she said.

Dr. Rich said her work situation couldn't be better. And if she has to work a bit longer than other phys-

icians to reap the financial rewards of her chosen profession, then so be it.

"My commitment is not to do medicine 24 hours a day, seven days a week. You go crazy. You have burnout. I'm content to [practice] a little bit longer and at a little bit slower pace," she said.

Dr. Rich said many of her medical school classmates shared that mindset, especially the ones who chose primary care rather than a specialty, such as obstetrics.

"When you choose a specialty, you do it knowing that people's appendixes need to come out at 3 a.m., and babies come 24 hours a day. They choose that different lifestyle," she said.

"[The mindset for younger doctors is] we need to be available, but we have to have time for ourselves, also. Medicine used to be a doctor's whole life. A lot of times their families came second. Their children got to see them when it was convenient for the patients. It was a completely different way of life. Medicine is evolving. There's no doubt about it," she said. ■

# Collect Bad Debt

- Cheaper
- Faster
- In compliance with the Law



If you've always used a collection agency... WHY?

Cut out the middle man by retaining the Mike Maggio Law Firm.

Save time. Save money.  
Be in compliance with the law.

Have you always used a collection agency because "that's the way you've always done it?"

*Try a new way. . . tip the scales in your favor, call Mike Maggio today.*

## MAGGIO LAW FIRM

*your collection law firm*

Offices in Conway and Searcy • 1-800-600-3201

[www.ebaddebt.com](http://www.ebaddebt.com)

## HEALTHY WEALTHY & WISE.

*Financial  
strategies  
specifically for  
physicians.*

At Hutchinson/Ifrah, we understand the issues that put a physician's practice and personal assets at risk. But our idea of being healthy, wealthy and wise is more than simply saving on taxes and protecting your assets, it's about maximizing your investment potential and planning for a tax-free retirement. Give us a call at 501/223-9190 and let us show you how we can help physicians achieve a healthy bottom line.



**Hutchinson/Ifrah  
Financial Services, Inc.**

*Registered Investment Advisors*

WE REALIZE YOUR POTENTIAL.

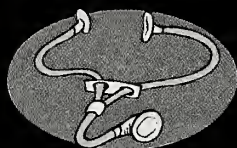
12511 Cantrell Road • Little Rock, Arkansas 72223

(501) 223-9190 • 800-635-9985

[www.hutchinson-ifrah.com](http://www.hutchinson-ifrah.com)



# CARDIOLOGY



## Right Ventricular Infarction

HANI A. RAZEK, MD — EDITOR: EUGENE S. SMITH, III, MD

*A common complication of inferior wall infarction is right ventricular infarction. Some aspects of its treatment differ from standard treatment of myocardial infarction, making its recognition of great importance. The following case leads to a discussion of this disorder.*

### Patient Presentation

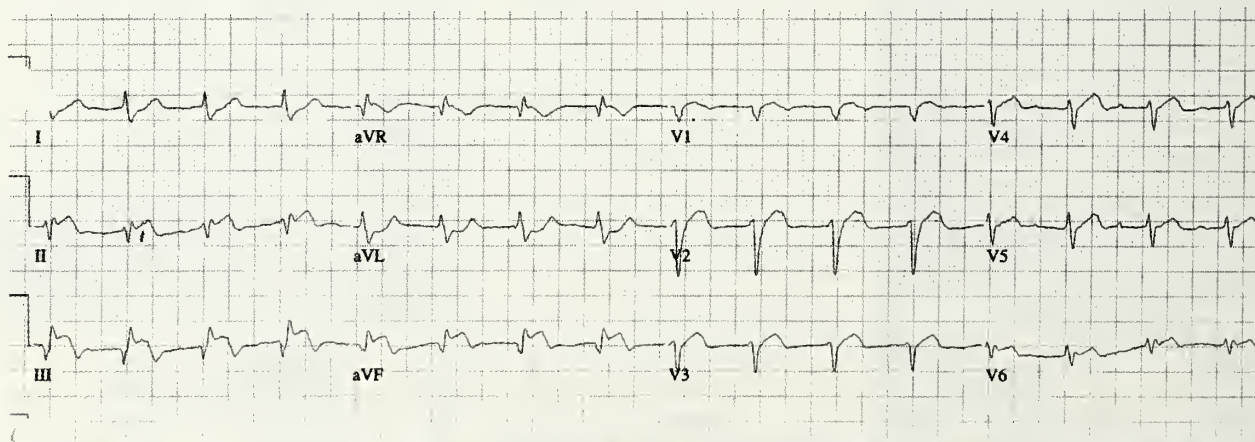
68-year-old male with history of long standing systemic arterial hypertension and diabetes mellitus who presented with severe substernal chest pain associated with nausea and diaphoresis lasting for almost 24 hours. There was no past history of angina. He also developed dyspnea on mild exertion but denied paroxysmal nocturnal dyspnea or orthopnea. Medications included glipizide, metformin, fosinopril and paroxetine.

Physical examination revealed a blood pressure of 114/72 mmHg; pulse 95 beats per minute; respiratory rate 22 per minute. Physical examination was unremarkable except for mild jugular venous distention with hepatojugular reflux. Chest X-ray was unremarkable. Initial laboratory studies revealed creatine kinase 311 U/L with MB fraction of 9 ng/ml and troponin I 95.5 ng/ml. Electrocardiogram revealed sinus rhythm with first degree atrioventricular block and ST segment elevation of 2-3 mm with pathological Q waves in inferior leads II, III, AVF consistent with acute inferior myocardial infarction (fig.1). Right precordial leads revealed 1-2 mm ST segment elevation in V3R, V4R, V5R, and V6R consistent with a concomitant acute right ventricular myo-

cardial infarction (fig. 2). Catheterization revealed triple vessel disease with proximal right coronary artery occlusion with retrograde collaterals from the left coronary artery. MUGA scan with right ventricular first pass scan showed left ventricular ejection fraction of 63% with normal wall motion and a dilated right ventricle with global hypokinesis and an ejection fraction of 21%. Patient underwent a successful four-vessel cardiovascular bypass grafting.

### Discussion

Right ventricular infarction (RVI) is not diagnosed as often as it occurs. It accompanies inferior-posterior wall myocardial infarctions (MI) in 30–50% of the patients.<sup>1</sup> It rarely involves only the right ventricle (RV). Acute

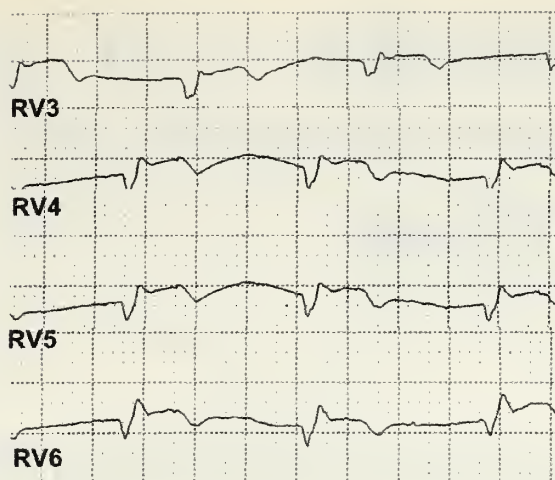


**Fig. 1.** Electrocardiogram revealed sinus rhythm with first degree atrioventricular block and ST segment elevation of 2-3 mm with pathological Q waves in inferior leads (II, III, AVF) consistent with acute inferior myocardial infarction.

occlusion of the right coronary artery proximal to the right ventricular branches results in dysfunction but not all occlusions result in RVI. Several factors account for this including: the presence of more collateral vessels from left to right, coronary perfusion of the right ventricle occurring in both systole and diastole, and a lower oxygen demand of the right ventricle compared to the left.<sup>2</sup>

Ischemia or infarction of the right ventricle results in a decrease in right ventricular compliance, reduction in filling, and a decrease in RV stroke volume resulting in a decrease in left ventricular filling and cardiac output. In addition to this, ischemia or infarction of the right ventricle causes RV dilatation resulting in a shift of the interventricular septum to the left as well as causing an increase in intra-pericardial pressure. This results in a decrease in the left ventricular compliance and cardiac output.<sup>3</sup>

Clinical recognition of acute RVI is important, as it is associated with considerable mortality and morbidity. It should be suspected in any patient with acute inferior wall myocardial infarction (IWMI). Its presence identifies a high-risk subgroup with potential life threatening consequences. It should be recognized so that therapies that lower right heart preload like nitrates, morphine and diuretics be used with caution. Atrial infarction, sinus bradycardia, and atrioventricular block frequently accompany RVI. The triad of hypotension, elevated jugular venous pressure, and clear lung fields has been recognized as an indicator for RVI in the setting of acute inferior-posterior myocardial infarction.<sup>4</sup> Pulsus paradoxus and Kussmaul's sign have been reported. The presence of elevated JVP and Kussmaul's sign in the setting of acute IWMI indicates a hemodynamically significant RVI (specificity 100%, sensitivity 88%).<sup>4</sup> Careful examination of the jugular venous pulse serves as an important diagnostic tool. Patients with intact right atrial function have enhanced A wave and X descent with decreased Y descent, but patients



**Fig. 2.** Right precordial electrocardiogram revealed sinus rhythm with first degree atrioventricular block and ST segment elevation of 1-2 mm with pathological Q waves in right precordial leads (V3R, V4R, V5R, and V6R) consistent with acute right ventricular myocardial infarction.

with depressed right atrial function have depressed A wave, X descent and Y descent. This finding signifies right atrial infarct, is a bad prognostic indicator.<sup>2</sup> Tricuspid regurgitation may result from right ventricle dilation. High-grade atrioventricular block may also occur.

Electrocardiogram is the most reliable and simple diagnostic tool for diagnosis. In order to diagnose RVI, it is imperative to obtain right-sided precordial leads in patients with inferior wall infarcts. RVI can be diagnosed with a predictive accuracy above 80% by the presence of ST segment elevation greater than or equal to 1 mm in right-sided precordial lead V4R in the presence of an acute inferior wall myocardial infarction. ST segment elevation in V4R is a strong independent predictor of major complications and in hospital mortality. ST segment elevation in right precordial leads is transient and may be absent in 50% of patients with RVI after 12 hours of onset of chest pain.<sup>5</sup> Complete atrioventricular block, right bundle branch block, and atrial fibrillation are among the most common dysrhythmias associated with RVI. Abnormal echocardiogram findings include right ventricular dilatation, right ventricular dyskinesis, reversed septal curvature and right atrial enlargement. The presence of interatrial septal bowing indicates a concomitant right atrial infarction

which is an important prognostic indicator and is a predictor of hypotension and higher mortality.<sup>6</sup> Pulmonary artery catheterization can confirm RVI by hemodynamic measurement when the right atrial pressure exceeds 10 mmHg and the ratio of right atrial pressure to pulmonary capillary wedge pressure exceeds 0.8 (normal value less than 0.6).<sup>1</sup>

Treatment involves standard reperfusion therapy for the acute left ventricular infarction using thrombolytics or primary angioplasty. In patients with hypotension, ventricular preload is optimized using isotonic saline to increase right ventricular filling pressure. Such optimization usually requires monitoring with a pulmonary artery catheter. Medications that reduce preload like diuretics, nitrates, morphine, and vasodilators should be used with caution. Once RV filling pressures are adequate, inotropic support using dobutamine has been shown to improve both right and left ventricular function.<sup>3</sup> Inotropic support should be started if cardiac output fails to increase after volume loading. Patients with severe hypotension may require dopamine for restoration of blood pressure and perfusion. Maintenance of atrioventricular synchrony is crucial to maximize cardiac output. If a patient develops atrioventricular block, atropine may restore sinus rhythm but some patients require atrioventricular sequential pacing. Aminophylline has been reported to restore sinus rhythm in acute atrioventricular block.<sup>7</sup>

In summary, RVI occurs in one third of acute inferior infarctions resulting in right ventricular dysfunction. All patients with acute inferior wall infarction should be evaluated for concomitant RVI with right-sided electrocardiogram. Early recognition of RVI is crucial in the management of an acute inferior wall infarction. Avoidance of preload reducing agents is an important aspect of management. A majority of patients who survive the acute phase may have a complete recovery of right ventricular function



# ARKANSAS

## EMERGENCY DEPARTMENT OPPORTUNITIES

# EmCare

Leader in Physician Practice Management

### BAPTIST MEMORIAL HOSPITAL – BLYTHEVILLE, ARKANSAS

- 16,000 Annual Patient Volume
- 12 Hour Shifts
- New 10 Bed ED
- BP/BC EM or PC
- Relocation Allowance
- Signing Bonus

Contact: Lisa Clayton @ (800) 362-2731 ext. 2718 Fax: (214) 712-2444 or  
Email: Lisa\_Clayton@EmCare.com

### CRITTENDEN MEMORIAL HOSPITAL – WEST MEMPHIS, ARKANSAS

- 17,000 Annual Patient Volume
- 12 Hour Shifts
- 10 Bed ED
- BP/BC EM or PC
- Relocation Allowance
- Signing Bonus

Contact: Jennifer Strouse @ (800) 362-2731 ext. 2014 Fax: (214) 712-2444 or  
Email: Jennifer\_Strouse@EmCare.com

**The EmCare Mission:** To serve and support physicians, hospitals, and other healthcare clients in providing high-quality patient care.

**We Offer Competitive Compensation & Excellent Benefits**

An Equal Opportunity Employer

[www.EmCare.com](http://www.EmCare.com)

## ACHIEVING SUCCESS ENTITLES YOU TO PRIVILEGES IN LIFE

Achieving your personal goals often requires a planned balance of financial management, including checking, loans, trust, investment products\* and services.

At Regions, we offer Private Banking to complement your success. We provide a level of service to efficiently meet your needs and maximize your valuable time. Whether you require business or personal services, you can rely on one of our private bankers to help ensure your goals are met by provided uncompromising, convenient service. To find out more about the special attention you deserve, please call us today.

Contact our Private  
Banking Department  
371-6613

# PRIVATE BANKING

# Regions Bank

[www.regionsbank.com](http://www.regionsbank.com)



\* Investments purchased through Regions Investment Company, Inc. are not deposits of the bank or guaranteed or insured by the bank, the FDIC or any government agency. Investments can assume risk including loss of principle. Regions is a member of NASD and SIPC.

MEMBER  
FDIC

suggesting right ventricular stunning rather than necrosis as a cause of right ventricular dysfunction. ■

Drs. Razek and Smith are with the department of internal medicine, division of cardiology, UAMS Medical Center and John L. McClellan Memorial Veterans Hospital in Little Rock.

### References:

1. Dell'Italia LJ, Starling MR, Crawford MH et al: Right ventricular infarction: Identification by hemodynamic measurements before and after volume loading and correlation with noninvasive techniques. J Am Coll Cardiol 1984;4:931-939
2. Goldstein JA, Barzilai B, Rosamond TL et al: Determinants of hemodynamic compromise with severe right ventricular infarction. Circulation 1990;82:359-368
3. Dell'Italia LJ, Starling MR, Blumhardt R et al: Comparative effect of volume loading, dobutamine, and nitroprusside in patients with predominant right ventricular infarction. Circulation 1985;72:1327-1335
4. Dell'Italia LJ, Starling MR, O'Rourke RA: Physical examination for exclusion of hemodynamically important right ventricular infarction. Ann Intern Med 1983;99:608-611
5. Klein HO, Tordjman T, Ninio R et al: The early recognition of right ventricular infarction: Diagnostic accuracy of the electrocardiographic V4R lead. Circulation 1983;67:558-565
6. Lopez-Sendon J, Lopez de Sa E, Roldan I et al: Inversion of the normal interatrial septum convexity in acute myocardial infarction: Incidence, clinical relevance and prognostic significance. J Am Coll Cardiol 1990;15:801-805
7. Goodfellow J, Walker PR: Reversal of atropine-resistant atrioventricular block with intravenous aminophylline in the early phase of inferior wall myocardial infarction following treatment with streptokinase. Eur Heart J 1995;16:862-865

# Arkansas Behind on National Quality Improvement Indicators

The Arkansas Foundation for Medical Care, in a nationwide initiative with the Health Care Financing Administration and other national quality improvement stockholders, plans to improve Arkansas' quality of care by targeting certain diseases and conditions.

Through the Health Care Quality Improvement Project,

national priorities have been chosen based on public health importance. These include acute myocardial infarction, breast cancer awareness, diabetes, heart failure, inpatient pneumonia, stroke and adult immunization. The following chart is an overview of where Arkansas stands regarding these national quality improvement indicators. ■

## Arkansas Score Card for National Quality Improvement Indicators

Clinical Topic	Quality Indicators	Arkansas Rate	National Median Rate	Arkansas Rank
<b>Acute Myocardial Infarction</b>	• Early administration of aspirin	75.1%	84%	50th
	• Aspirin at discharge	77.6%	85%	47th
	• Early administration of beta blockers	55.4%	64%	42nd
	• Beta blocker at discharge	62.4%	72%	42nd
	• ACE inhibitor at discharge for low ventricular ejection fraction	56.8%	71%	50th
	• Smoking cessation counseling during hospitalization	24.3%	40%	49th
<b>Pneumonia</b>	• Timely administration of initial antibiotic at hospital	88%	85%	14th
	• Appropriate initial empiric antibiotic administration	77.8%	79%	32nd
	• Blood culture prior to antibiotic administration	82%	82%	28th
	• Inpatient influenza vaccination (or screening)	5.9%	14%	50th
	• Inpatient pneumococcal vaccination (or screening)	4.2%	11%	48th
<b>Heart Failure</b>	• ACE inhibitors for low left ventricular ejection fraction	71.1%	N/A	50th
<b>Atrial Fibrillation/Stroke/TIA</b>	• Warfarin at discharge	50.2%	55%	39th
	• Antithrombotic at discharge	77.5%	83%	42nd
	• Avoiding use of sublingual nifedipine during acute phase of ischemic stroke	92.2%	95%	35th
<b>Diabetes</b>	• Annual HbA1c	57%	71%	48th
	• Biennial lipids	43%	57%	48th
	• Biennial eye exam	67%	69%	34th
<b>Adult Immunization*</b>	• Pneumococcal immunization	39.1%	46%	44th
	• Influenza immunization	61.1%	66%	43rd
<b>Breast Cancer Prevention</b>	• HEDIS mammography rate	30.72%	N/A	N/A
	• Medicare Biennial mammography rate	49.7%	56%	48th

State rank is based on a total of 53 U.S. states and territories \*Source: BRFSS 1997, Arkansas Foundation for Medical Care



# Quality Improvement Programs Depend on Team Work

GEOFFREY GOLDSMITH, MD, MPH—KRISTIN WARD, MSPH — JOSEPH BANKEN, N, PH.D. — JUDY GRAINGER, LPN

## Introduction

The medical literature documents the critical need to improve the quality of care.<sup>1</sup> There is little doubt that physicians and hospitals strive to provide the very best care, and this reality has led to an acceleration of formalized inpatient and outpatient Clinical Quality Improvement (CQI) programs over the past decade.

Clinical Quality Improvement as a process aims to yield the best clinical practices by reducing practice variance from best practice standards and thereby ensures that high quality care is delivered. Using practice guidelines derived for clinical experiments and/or recommendations of expert panels, achievement of best practices sometimes takes the form of multi-prong improvement efforts assembled into very prescriptive and compre-

hensive disease management programs.<sup>2</sup> Less rigorous approaches use clinical algorithms that set out prompts to help the provider choose interventions at key decision points in patient care. Formalizing a CQI program has proven effective in improving care in the ambulatory setting.<sup>3,4</sup>

Over the last several years, the University of Arkansas for Medical Science's department of family and community medicine has been experimenting with ways to incorporate quality improvement strategies into the family practice clinical setting. Our goal is not only to improve our patient care services but also to train family practice residents on how to incorporate quality improvement into the family practice clinical setting. We now have 12 projects designed to improve the quality of clinical practice (see Table 1). This paper

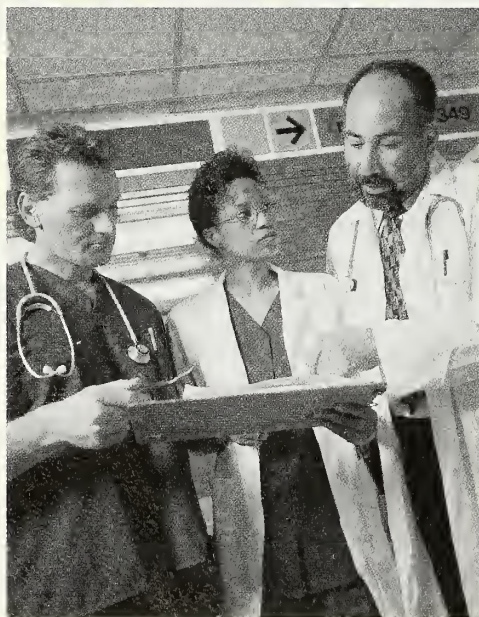
presents the issues that we found quite helpful as we began initiating our quality improvement program. A review of the relevant medical literature is intended to give the reader suggestions that might be helpful as their site considers establishing a quality improvement program. We share with the reader some of our observations, successes, setbacks and challenges.

## 1. Critical Issues That Affect the Quality of Care

### The Real World of Ambulatory Medical Practice and CQI

In outpatient practice, the outcome of care can be influenced by a host of factors not present or even systematically eliminated in the experimental setting.<sup>5</sup> CQI uses evidence-based medicine (EBM) as a way to standardize

**Table 1: Ongoing CQI Strategies in the Department of Family and Community Medicine**



### ONGOING PROJECTS

- Improve the efficiency of our clinical information system as an essential foundation for quality improvement
- Create interdisciplinary clinical teams as a strategy to promote best practice interventions
- Improve availability of medications to medically indigent patients
- Improve patient satisfaction
- Increase patient-centered activities such as improvements in practice management parameters
- Increase self-care
- Achieve the U.S. Preventive Task Force standards for best practices in immunization rates
- Achieve national expert panel guidelines for at least two chronic diseases commonly managed in the family practice setting (diabetes and depression)
- Improve trainees' prescribing practices for common disorders seen in the family practice setting
- Build quality improvement training into the residency curriculum
- Identify strategies that can sustain — over the long term — clinical quality improvement in the family practice setting
- Increase training of medical students in evidenced-based medicine

practice using the most scientific approach to care management. Since EBM uses randomized, blinded, placebo-controlled studies with carefully defined patient inclusions and exclusion criteria, generalization of EBM to primary care practice settings may be problematic. The other source for best practices is the use of guidelines derived from national expert panels. Such panels' recommendations may be far removed from the day to day realities of primary care.

As one questions how to achieve best care in family practice, it becomes apparent that results derived from tightly controlled experimental studies (EBM findings) and national expert panels must be tailored to the real world of primary care. Early on, we recognized that our family practice population isn't as rigorously defined ("sanitized") by diagnosis compared to the rigorous diagnostic and exclusionary standards used in scientific studies. Still, having CQI best practices standards based on the randomized clinical trials or national scientific panels is a useful starting point as one begins to establish CQI program.<sup>6</sup>

When patients evaluate quality of care they consider factors such as communication skills with their physician, courtesy of the office staff, how well the referral was handled to the sub-specialist, waiting time to reach the provider and accuracy of their bill and all other areas of practice management. These areas too must be part of a quality improvement program if one is to attain high quality from the patient's perspective. Thus, to be successful, the entire chain of events in ambulatory care and the entire primary care team (clinicians and office staff) must be considered in a CQI program.

### **Organizational Commitment to CQI**

Compliance to high standards all along the care continuum is very difficult to achieve.<sup>7,8</sup> Some corporations' almost fanatical leadership support of total quality improvement can prove as examples of the very deep commitment needed to achieve

superior outcomes in medical quality improvement activities.<sup>9</sup>

With process issues in mind, primary care practices need to attend to the following issues:

- Commitment of the organization's leadership to quality improvement;
- Resources allocation for CQI;
- Physician and staff commitment to weather the short-term failures mixed with successes that CQI brings;
- Organizational disruption and turmoil the redesign of the office processes that is an early part of CQI;
- Adequacy of the physician decision support systems;
- The disbelief within the practice that there are any significant problems in clinical care management;
- Availability of community; resources to aid vulnerable patients with chronic illnesses;
- Adequacy of the clinical information system that supports CQI;
- Adequacy of the data management system used to assess outcomes; and
- Adequacy of the patient centered issues that affect compliance and satisfaction.

### **Physician Compliance with Practice Guidelines**

The medical literature on quality improvement points out that some physicians won't readily follow practice guidelines.<sup>7,8</sup> Some of the more common reasons for hesitancy to follow care guidelines, even if the guidelines are supported in the scientific literature, are included in Table 2. We experienced many of these issues. One of the most common beliefs of physicians is their current medical practices are very good and there isn't a need to invest the time (which is considerable), cost (which can be significant) and disruption of the current care system (which may be modest to dramatic) that often is entailed in CQI programs. In dealing with this issue, one should know that physicians may not understand their knowledge shortcomings.<sup>10</sup> Studies

also show that providing physicians feedback on practice activities provide a wealth of useful information that may improve care.<sup>11</sup>

Physicians may not implement a guideline or disease management system because of "lack of outcome expectancy." That is, even if the new disease management system was endorsed as having the potential to improve outcomes, physicians believe that factors beyond the control of the physician may influence the probability that the change will have its intended effect.<sup>12</sup> This is based on the belief of many physicians that recommendations from national panels and/or clinical trials won't "work in the real world of my practice." The use of examples from like practices that were able to achieve better outcomes helps to address this concern.

Awareness, agreement, adoption and adherence must be addressed step by step with providers in order to change the norm of the practice group. Guidelines change over time and must be updated. Adherence to changing standards needs continuous attention (measure outcomes + reevaluate the change + reinforce the change + change the strategy changed if compliance isn't yielding better patient outcomes + re-teach staff and clinicians about the standard) if a guideline is to improve care. This has been a major issue in our practice and hardest part of the CQI process. Working on adherence isn't as much fun as the group enthusiasm for new project development. Thus, philosophical adoption of a guideline by the practice physicians is only the first step to incorporating a long-term change into the day to day procedures of the practice.

### **It Takes a Team to Achieve Extraordinary Ambulatory Care**

Our clinical experience and that of others is that it takes team effort to maintain high quality care.<sup>13</sup> This means the office staff not only need to embrace the opportunity to make improvements but just like providers,



**Table 2: Common Reasons Quality Improvement Fails in Medical Settings**

<b>Physician-related</b>	<b>Patients</b>	<b>Ancillary staff</b>
Don't agree that CQI is needed in the clinic	Don't believe their efforts/ideas will matter	Don't agree that CQI is a mission of mission of the clinic
Lack of awareness of a guideline	Not motivated in self care and their role	Not aware of practice guideline
Disagreements with guidelines	Lack of resources to implement to provider's plan	Disagreement about whether change is part of their job
Belief that even if the guideline is followed, it won't change the quality of care	Don't believe in the treatment plan but afraid to speak up	Lack of assurance that office change will lead to the desired change
Resistance in being told what to do	Lack of understanding of the plan	Resistance to change
No incentives or disincentives driving change	Lack of incentives to change	No incentives to change
Late adopters are naturally hesitant to change practice patterns	Weren't asked to participate actively in their care	Not willing to lead change
Lack of training inhibits acceptance of practice change (skills and/or knowledge deficit)	Inadequate patient education (knowledge deficit)	Inadequate training of ancillary staff
Lack of feedback, prompts and reminders that signal a change is needed	Lack of social support to implement the plan	Lack of feedback, prompts, and reminders
The medical system makes it difficult to adopt quality protocols	Lack of skills to implement the plan	Just too busy to invest time in making changes

staff need to understand the rationale for new approaches and have incentives to improve quality. Table 2 lists common issues that emerged as our practice adopted CQI programs.

Over time, human resources policies can lead to promotion and retention of staff who espouse and move the quality agenda forward.

### **Attention to Patient-Centered Care Will Improve Quality**

In addition to getting the providers and staff "aboard" on the quality improvement journey, one can't sail without attending to the importance of patient-centered strategies. As is typical for primary care practice, many patients have chronic diseases such as hypertension, high cholesterol, diabetes, coronary artery disease, musculo-skeletal pain and asthma. Most ambulatory chronic disease management depends on the patient and/or family to implement the care program. It is easy to see that even the best designed practice guidelines can be undone by the non-compliance to the treatment

plan. For example, studies on non-compliance with medications in hypertensives cite that about 50% of the reason our treatment doesn't work is due to patient non-compliance.<sup>14</sup> Patient-centered reasons patients don't achieve best outcomes appear in Table 2.

## **2. Strategies That Can Be Used to Enhance Quality**

### **Redesign the Practice and Creation of a Decision Support System**

In an office that uses a paper-based medical record system, chart audits are very costly and difficult to perform. Yet, an absolute requirement for quality improvement efforts is to perform chart audits. The paper chart audits can show opportunities to improve practice patterns and is certainly a reasonable approach for a non-computerized practice to start its CQI program.

Using the cumbersome and costly manual paper chart audit system, we rapidly came to the conclusion, that over the long term, an electronic

medical record (EMR) is an essential tool for quality improvement. The year-long EMR implementation process we used at our site is described in detail in an article in Medical Economics.<sup>15</sup> The result of adopting an EMR is that we improved our ability to monitor the quality of care, added quality improvement strategies into the software and dramatically reduced the cost of supporting quality improvement. Using the EMR, we now are able to do chart audits in one tenth the time and cost of manual surveys. We can query the EMR to structure quality reviews on patients fitting unique quality improvement topics of interest. An example is that a CQI survey might be designed to, "Find all patients ages 50-60 and check when they last had a flexible sigmoidoscopy or colonoscopy." We then can focus on deciding whether we should improve compliance with our standards for bowel cancer screening in this group of patients.

The EMR is now able to tailor an immunization prompt for each patient adjusted by the age and sex of the patient.

A very thorough study by the Health Care Finance Administration of 197 papers evaluating<sup>18</sup> strategies to change clinical behavior found that most effective strategies to improve clinical performance in the medical office involved office redesign, including prompts and reminders, patient notification systems, feedback to providers about their performance and standing orders.<sup>16</sup> These redesign issues can be accomplished first through having the office agree upon standard operating procedures and then through the use of an EMR. The above study was concerned with immunizations but practice redesign approaches have been found to be successful with chronic disease management.<sup>13</sup> We learned that even using such approaches to improving immunizations, the best redesign system can be defeated. We failed to monitor the patient outcomes regularly enough, paid inadequate attention to reeducate the office how to use the redesign and didn't tie human resources incentives closely enough to the change on outcomes. But with time, when initial attempts at improvements failed we tried other approaches.

### **Data Management Systems**

The EMR is an excellent aid for improving the quality of care but it is just one part of a CQI system. Most EMRs are not robust enough to support a CQI program's data management needs. A key factor in improving chronic disorders is to create a registry of patients with a particular disorder. This allows one to set a practice's baseline care and to compare improvement as the practice changes its care systems. Access, Excel or SPSS can be used to enter and manipulate data in a small to moderate size practice. Such a data management system is another needed component of an office-based CQI program.

We are experimenting with Web-based data storage and analysis tools supplied by a national health outcomes company that allows our practice to compare our practice

parameters in the care of depressed patients to other sites.<sup>17</sup>

### **Using Educational Strategies to Change Physician Behavior**

As one initiates a quality improvement program, there is a seductive notion that all the practice needs to do to achieve improved practice outcomes is to improve the knowledge base of the family physician. Lectures (passive learning) linked with active strategies (office changes, clinical audits or administrative changes) is one way to change clinical behavior.<sup>4,18</sup> But improving clinicians' knowledge about best practices guideline may not be adequate to generate practice changes.<sup>19,12</sup> One needs to combine knowledge improvement and practice changes.

Rational decision making theory would argue that the physician will do what is rewarded as long as the result is efficacious adoption of change.

According to research on change, people appear to fall into various categories in terms of the rapidity they incorporate change into their work activities.<sup>24</sup> There are the individuals who just don't want to be "hassled" with inconvenience of changes. Others who aren't leaders of change look to the formal and informal leaders for cues and permission to make changes. Then there are late adopters that some term "laggards" in the medical setting.<sup>24</sup> Others may consider them as "resisters." They want and need lots of information before they are convinced of the value of change. Unless the resisters are in positions of power, it is best to leave this group to the last. After most of the kinks in the CQI system have been resolved, their resistance is often less vigorous — some resisters may have even converted to adopters by then. We found that incentives to bring along resisters include peer pressure, adding lots of educational support in coping with the change, making change gradual and finally make it difficult to continue to do things the old way.

Organizational management theory points out that in managing change, one must consider the

organization's power hierarchy (how are decisions made) and sources of support and resistance once a decision is made (determines how successful implementation will be). A four quadrant grid can be constructed with "organizational power" on one axis and level of support (organizational resistance to enthusiastic support) on the other. In quadrant one, resides physicians and administrative staff with high power and high support for CQI. One is well served to work hardest at first in this quadrant. That is, one aims to influence physicians and administrators who have the highest power (authority, either formal or informal) and lowest resistance to change. This is preferable to aiming initially in the other quadrants (low power and high support, high power and low support and high power and high resistance).

Leadership support is essential for sustaining quality improvement. Improving quality involves a gradual set of "experiments" that progressively result in improvement. One starts a quality improvement project with the hope a small project might improve care. If the pilot is successful, the practice expands the trial eventually incorporating the improvements into the usual practice pattern. If the pilot is a failure, one must have the practice's support to continue the improvement process by trying other "experiments." CQI strategies can yield great long-term gains but here are many people who, at the first sign of a pilot experiment that fails to improve care, will argue to go back to what has worked in the past and drop CQI efforts. Support from the senior leadership is essential to reinforce the value of continuously striving for long-term clinical improvements and protecting the CQI budget along the way.

### **Patient-Centered Strategies**

Patient-centered activities include adapting the practice to patients' needs, empowering the patient through self-care and providing patient assistance through use of community resources. Most primary care practices can't afford



a social worker to mobilize community support networks to aid them in the management of their chronic diseases. Yet, many primary care patients lack the resources and social support systems to aid them in the management of their disorders. It is essential to craft together community resources if one is to optimize management of chronic diseases in vulnerable patient populations.<sup>13</sup> Self-care can be taught to patients by ancillary staff or the physician but patient education services aren't well reimbursed.

As we reviewed the medication use of many of our patients with chronic disorders, it became clear that a large number of patients couldn't afford the medications we prescribed. The need for free medications far outstripped our sample cabinet capacity. We targeted this area as a top priority for improving our patient-centered care strategies. Working closely with our College of Pharmacy and pharmaceutical companies, we implemented a free medication program (called the patient assistance program) for patients who met the pharmaceutical companies' financial need criteria. Any private practice can establish a similar program making use of the office staff to support the administrative workload.

Over the past year, the first year of the free medication program, \$106,000 in free medications were provided for our most needy patients — about 5.5 times the cost of the program. Now in the second year of the program, the utilization is increasing by about 50%. We have developed administrative systems that will allow us to increase the amount of medications we provide without adding any staff costs. The result of the free medications program has been a dramatic improvement of compliance with medication use. Interestingly, a local television station did a news story on our free medications program and this yielded hundreds of patient calls to us. We signed up many patients for our teaching practice who had health insurance but no medication coverage. This was a very unexpected and positive outcome for our residents' practice panel and addressed a needed

community service. Some private physicians make use of this approach to providing their patients with medications and pay for the staff cost by charging a small administrative fee to do the paperwork.

Patients who don't understand their physician's instructions aren't likely to follow even the best-designed treatment plan, even when the medications are free. One study of diabetic patients showed that the reasons for non-compliance patients included: dietary issues (25%), cost (17%), forgetfulness (14%), time and lifestyle (20%) and complicated dosing.<sup>25</sup> Other studies of elderly show that up to one-third of elderly patient's illiteracy impairs their medical care.<sup>26</sup> It is critical to tailor patient instructions to the patients' education level. For example, practices that provide patients with medical information about immunizations written at fifth-grade level are able to dramatically improve compliance.<sup>27</sup> As a priority in the area of self-care, we have adopted patient education as another part of our patient centered practice activities. We have a combination of patient educators, nurses, PharmDs and our clinicians who provide these services and are able to recover part of the costs for such care through close attention to proper coding.

### Lessons and Future Directions

Simplicity in quality improvement has been noted to be an essential ingredient of successful projects.<sup>28</sup> This has been our experience as well. We are using an Internet-based module created by the Centers for Outcomes Research.<sup>17</sup> This module is simple, straightforward and easy to use. The screening questionnaire we now use contains three items and does not require scoring. At a glance, the nurse or doctor can decide if further testing is necessary. This is the kind of approach that is most likely to be adopted.

Use of clinical guidelines and standing orders must not replace good clinical judgment. In fact, over-reliance on computerized prompts and standing protocols without regular reviews and training of staff can open the practice into a signi-

ficant problem. For example, an audit of pharmacy computer systems to prevent medication errors found a host of missed opportunities to prevent problems and just plain oversights in over 60% of the systems tested, according to the Institute for Safe Medication Practices.<sup>29</sup> Our own experience is that CQI is a constant active learning process that requires substantial feedback to ensure that the approaches being used are affecting positive changes. We decided to do a modest amount of evaluation (patient satisfaction measures, chart audits of care, productivity measurement in the free medication program, productivity and quality of the CME programs and educational program evaluation). This approach had a significant downside. It is difficult to use a quantitative approach to deciding which CQI project should be supported with scarce resources. In areas where we didn't regularly measure patient outcomes (for example, immunization rates), we could not quickly change our CQI strategy. In our third year of the CQI project, we plan to do far more intensive evaluation.

It is clear that changing physician behavior is a very difficult assignment. There seems to be a counterbalancing "spirit" in any practice that can undo CQI strategies unless energy is made to maintain the improvements. But with adequate attention to the rationale for such change, a well thought out step-by-step approach to address physicians' concerns, an adequate educational support and incentives, we found that progress can be made.

In most primary care practices, quality of care efforts aren't reimbursed with incentives. It may be difficult to support the costs of a comprehensive quality improvement program within an office-based primary care setting without financial incentives to do so although portions of a CQI appear to be sustainable. ■

### References

1. Chassin MR, et. al., The urgent need to improve health care quality. *JAMA*, 280: 1000-1005, 1998.
2. Aucott JN, Pelecaos E, Dombrowski

- R et. al, Implementation of local guidelines for cost effective management of hypertension. A trial of the firm system. *J Gen Int Med*, 11: 139-145, 1996.
3. Coleman and Endsley, Quality Improvement, Family Medicine Management, March 1999.
4. Solomon DH, Hashimoto H, Daltroy L, and Liang MH, Techniques to improve physicians' use of diagnostic tests, *JAMA*, 280, 23, 2020-2027, December 16, 1998.
5. Tanenbaum T, Evidence and expertise: The challenge of the outcomes Movement to medical professionalism, *Academic Medicine*, 74: July, 757-763, 1999
6. Sackett DL, Richardson WS, Rosenberg W, Haynes RB. Evidence-based Medicine: How to Practice and Teach EBM. New York: Churchill Livingstone, 1997.
7. Pathman DE, Konrad TR, et. al, From awareness to adherence to clinical guidelines compliance: The case of pediatric vaccine recommendations, *Medical Care*, 4: 873-889, 1996.
8. Bandura A, Social Foundation of thought and action: A social cognitive theory. Englewood Cliffs, NJ, Prentice-Hall, Inc., 1986.
9. Pyzdek T, Six sigma is primarily a management program, 26, *Quality Digest*, June, 1999.
10. Tracy et. al, The validity of general practitioners self assessment of knowledge, *BMJ*, 315, 1426-8, 1997.
11. Mason J and Haas D, Organizational learning form utilization reiew, *Group Practice Journal*, 14-18, October 1998.
12. Cabana M, Barriers to Guideline adherence. *Am. Journal of Managed Care*, vol.4, No.12, sup. S741-747, 1998
13. Idealized Practice Collaborative, Institute for Healthcare Improvement, Boston, MA, 1999
14. Stephenson J, Non-compliance may cause half of anti-hypertensive drug "failures", *JAMA*, 282, 4, 313-314, July 28, 1999
15. Lowes R, Switching from paper to computerized charts, *Medical Economics*, May 24, 1999.
16. Hinman AR, Taskforce on Community Preventive Services, National Conference on Adult Immunization, CDC, Atlanta, 1999
17. Brown W, Depression Outcomes Program, Arkansas Center for Health Improvement, UAMS, Little Rock, Arkansas, 1999
18. Davis D, O'Brien MA, Freemantle N, et. al., Impact of formal continuing medical education: Do conferences, workshops, rounds, and other traditional continuing education activities change physician behavior or health care outcomes?, *JAMA*, 282: 867-874, 1999.
19. Joshi MS, Bernard D B, Classic CQI Integrated with Comprehensive Disease Management as a Model for Performance Improvement, *Journal of Quality Improvement*, volume 25, number 8, 383-395, 1999.
20. Hull B, Benchmarking may challenge perceptions, *MGMA Update*, vol. 38, No. 15, Aug. 1, page 1, 1999
21. Wright RA: A performance evaluation system for primary care providers in a community health services program, *J Ambulatory Care Management*, 20, 4, 74-86, 1997.
22. Greco P J, Eisenberg J M, Changing physician's practices. *NEJM* 329: 1271-1273, 1973.
23. Kanter R M, From status to contribution: Some organizational implications for the changing basis for pay. *ACEP Executive Brief*: 64, 1, 12-27, 30-37, January, 1987.
24. Steffensen FH, Sorensen HT, and Olesen F, Diffusion of new drugs in Danish general practice, *Family Practice*, vol. 16, no.4, 407-413, 1999
25. Novo Nordisk, in *Physicians Financial News*, 5, January 15, 1999.
26. McKinney M, Medicare Patients' illiteracy impairs medical care, *Medical Tribune*, 19, March 18, 1999.
27. Jacobson TA, Thomas DM, Morton FJ, et. al., Use of low-literacy patient education tool to enhance pneumococcal vaccination rates: a randomized controlled trial, *JAMA*, vol. 282, no. 7; 646-650, August 18, 1999.
28. Angstman G, Simplicity leads to success with guidelines, *Medical Management Network*, 5, 10, 1, Medical Management Network, November 1997.
29. Practice Beat, Many Rx errors slip past hospital computers, *Medical Economics*, 28-34, July 26, 1999.

# Let Us Hear From You!

**You can now e-mail AMS  
at the  
following addresses:**

**Main address:**  
**ams@arkmed.org**  
**Ken LaMastus:**  
**klamastus@arkmed.org**  
**Lynn Zeno:**  
**zeno@arkmed.org**  
**David Wroten:**  
**dwroten@arkmed.org**  
**Kay Waldo:**  
**kwaldo@arkmed.org**  
**Journal:**  
**journal@arkmed.org**



**Plus. . .**  
**Visit our web site at:**  
**www.arkmed.org**

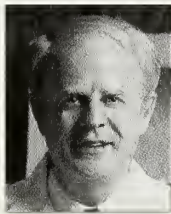


# PEOPLE+EVENTS

## HONORED

### **Dr. Shock Appointed UAMS Interim Dean**

Dr. John P. Shock has been named interim dean of the University of Arkansas for Medical Sciences' College of Medicine. Dr. I. Dodd Wilson, current dean of the college, will succeed Dr. Harry P. Ward as Dr. Shock's chancellor of UAMS.



Dr. Shock

Dr. Shock will take over dean duties in mid-October. The search for a new dean will begin soon and follow the traditional academic executive search process. As interim dean, Dr. Shock will handle the day-to-day responsibilities for the dean's office, maintain his role as chairman of the department of ophthalmology and continue to see patients weekly.

### **UAMS Physician Heads Orthopedic Group**

Dr. Carl Nelson, chairman and a professor of the department of orthopedic surgery and the director of the Center for Hip and Knee Surgery at UAMS, has been named president of the Mid-America Orthopedic Association.

### **Little Rock Physician Profiled in Magazine**

Dr. Nicholas J. Paslidis of Little Rock was profiled in the April 10 issue of *Medical Economics*.

The article focused primarily on Dr. Paslidis' work

with White River Rural Health Centers, a network of 12 primary care clinics serving older and indigent patients in Searcy, Kensett, Des Arc and Hazen.

The Greek native completed medical school in the United States and earned a doctoral degree in molecular biology before beginning an internal medicine residency at the University of Texas at Houston. In 1995, he moved to Boston with his wife and two daughters for a fellowship in gastroenterology at Harvard Medical School. He planned on a career in academic medicine but experienced a change of heart six months into his fellowship.

The pace of his practice for the last five years has been hectic. Dr. Paslidis works an average of 18 hours a day and drives an average of 200 miles each day.

### **Dr. Golden Elected to Internal Medicine Society**

Dr. William E. Golden, an internist and geriatrician, has been elected to the board of regents of the American College of Physicians-American Society of Internal Medicine. A graduate of Baylor College of Medicine, Dr. Golden is the director of general internal medicine and professor of medicine for UAMS.

### **Dr. Ross Certified as Medical Review Officer**

Dr. R.W. Ross of Cornerstone Family Clinic in Van Buren recently became certified as a medical review officer.

The American Association of Medical Review Officers Inc., created in 1991, is a nonprofit medical society dedicated to establishing national standards and certification of medical practitioners and other professionals in the field of drug and alcohol testing. This certification process has involved training programs, the establishment of standard practices and procedures and the administration of voluntary certification examinations.

Dr. Ross is the medical director of the Cornerstone Medical Group and Ozark Medical Arts in Ozark.

### **Dr. Davis Inducted into Honor Society**

Dr. R. Keith Davis of El Dorado recently was inducted into the Alpha Omega Alpha national honor medical society at a April 18 banquet held to honor new members at the Pleasant Valley Country Club in Little Rock.

Alpha Omega Alpha is the only national honor medical society in the world. Its purpose is to recognize and perpetuate excellence in the medical profession.

Dr. Davis currently is completing a three-year residency program in family practice at the El Dorado AHEC.

## EVENTS

### **New Prostate Cancer Foundation Wages War**

The Arkansas Prostate Cancer Foundation needs the help of individuals, organizations and institutions across Arkansas to continue waging its war on prostate cancer.

Prostate cancer is the most commonly diagnosed cancer in men. American men have a one in six lifetime risk of developing the disease, and the risk rises dramatically with age. For instance, by the time a man reaches the age of 50, there's a 30% chance he has prostate cancer.

The goal of the Arkansas Prostate Cancer Foundation, a nonprofit advocacy group for residents of the state of Arkansas, is to raise the awareness of the high risk of prostate cancer, to facilitate early diagnosis and to improve treatment. To accomplish this, the foundation supports education, research and treatment programs and facilities throughout the state.

The foundation was the vision of James C. East and Dr. Graham F. Greene, both of Little Rock.

The foundation is currently soliciting leadership contributions. Become a founder, partner, sustainer, benefactor or supporter by making a pledge to the Arkansas Prostate Cancer Foundation, P.O. Box 7317, Little Rock, AR, 72217. For more information, (501) 603-7433.

### **Community Match Program Adds Towns**

At a recent Rural Medicine Student Leadership Association luncheon in Little Rock, 14 UAMS medical students and nine Arkansas communities made a mutual commitment. Each community will sponsor a student by paying half of his or her medical school expenses, about \$8,250 a year for four years. The state will pay the other

half. In return, the student will work as a primary care physician in the sponsoring community for four years following his or her graduation and residency.

Thirty-nine communities currently participate in this Community Match Program. Six new communities will be added this fall.

Enacted by the state legislature in 1995, the program differs from the older rural loan programs because it carries stiff penalties for those students who do not fulfill their contract.

UAMS students attending the luncheon and where they will practice: Barry Pierce, Stuttgart; Bill Cobb, Newport; Garrett Sanford, Newport; Sidney Collins, Monticello; Nicole Bowen, Tuckerman; Jason Vanderburg, Brinkley; Stacy Crider, Newport; Justin Hayes, Booneville; Brian Oge, Nashville; Garry Stewart, Perryville; Jeff Graham, Osceola; Brannon Treece, Osceola; and Ken Dill, Osceola.

## RETIREMENTS

### Des Arc Doctor Retires After 53 Years

Dr. Gerald M. Schumann of Des Arc recently retired after 53 years of service to the community.

He was honored with a plaque and several personal gifts by staff at the White River Medical Center.

Dr. Schumann, who is known around town for the many ball caps he wore at the office, gained national recognition when he was named the No. 2 "Country Doctor of the Year" two years ago.

He came to Des Arc in 1946 after receiving his medical degree from Columbia University in New York City. Before heading to Des Arc, Dr. Schumann served as a surgeon in the U.S. Army during World War II. At one time, he opened a hospital in Des Arc. It closed after facilities in nearby towns, such as Searcy, began to grow. But the Schumann Clinic remained open at Third and Main streets. The building is now deeded to the city of Des Arc.

### West Memphis Doctor Honored By Community

Dr. Chester Peebles, an internal medicine physician in West Memphis, was recently honored with a retirement

At the  
**HEART**  
of quality  
health care...



...there's  
**HealthLink.**

**HealthLink of Arkansas**  
is proud to offer:

- Convenient service
- Strong multi-payor distribution channel
- Flexible health care programs
- Well-established regional network
- Responsive local presence

**Join HealthLink Today!**

**1-877-284-0101**

**HealthLink**  
of Arkansas



Managed Health Care

## For the Investments of your Life...



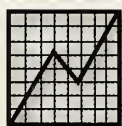
**I**NVESTING is not "The End" Investing is "The Means"  
The desired end is reached by planning, growing and finishing well. Our expertise is implementing investment strategies that best empower *your* plans for growing and finishing well.

Clients include individuals, retirement plans, trusts and foundations. All enjoy a competitive fee-only service. We can add value and peace of mind to the investments of *your* life.

(Left to Right) Bill Smith, Keith McCullough,  
Jim Strawn and Stephen Chaffin.



THE BEST CHOICE IS AN INDEPENDENT INVESTMENT ADVISOR



**SMITH  
CAPITAL  
MANAGEMENT**

Pleasant Valley Office Center  
12115 Hinson Road  
Little Rock, AR 72212  
501/228-0040 or 800/866-2615  
fax 501/228-0047



# MEDICAL OFFICE SPACE

**DOCTORS BUILDING**  
500 South University Avenue  
Little Rock, Arkansas

Suites Available ranging from  
496 sq. ft. to 1,618 sq. ft.

Professional Management  
Maintenance 24 hours a day, 365 days a year  
Nightly janitorial service plus Day Maid  
Free Doctors Parking Lot -  
Or Low Cost Reserved Parking  
Free Use of Well Appointed Conference/Club Room  
Ancillary Services in Building

**Location convenient to all area Hospitals**  
including Baptist, St. Vincent Doctors,  
St. Vincent Infirmary, UAMS, VA  
and Arkansas Children's.

**CONTACT**  
**Betty Garcia - 664-1812**  
VISIT OUR WEBSITE [www.lrma.com](http://www.lrma.com)

party celebrating his 38 years of service in Crittenden County.

Ross Hooper, chief executive officer of Crittenden Memorial Hospital, presented Dr. Peeples with a plaque honoring his service in West Memphis. With his newfound time, Dr. Peeples plans to enjoy Lake Hamilton in Hot Springs, fish at East Lake, attend Redbirds baseball games and watch his grandchildren's ball games.

Dr. Peeples attended medical school at the University of Tennessee and spent two years in the Air Force as a flight surgeon.

Dr. Peeples will remain medical director of the recuperative clinic at Crittenden Memorial Hospital and plans to run for reelection to the West Memphis City Hall this fall.

## OBITUARY

### Stanley R. McEwen, MD

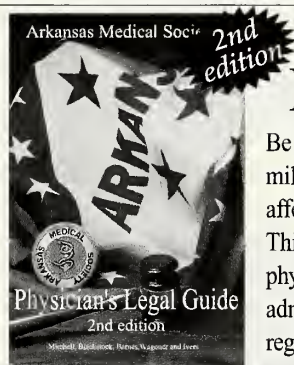
Dr. Stanley R. McEwen, 73, died June 1 in Fort Smith.

Dr. McEwen was the founding member of the Ophthalmology Clinic in Fort Smith, which is now the Eye Group. He first started practicing in Greensburg, Kan., after two years as a general medical doctor in the Navy during the Korean War. He was chief of ophthalmology service at Veterans Hospital at Kansas City, Mo.

He began college at Tulane University in New Orleans and graduated from Kansas University Medical School. He completed his residency training at KU.

Dr. McEwen was a retired Navy commander, patron member of the National Rifle Association, a life member of the Old Fort Gun Club, member of the Noon Civics Club and member of the American Medical Association, Arkansas Medical Society, American College of Surgeons, Society of Military Ophthalmologists and American Academy of Ophthalmology. He was a member of the Sons of the American Revolution, Phi Delta Theta fraternity and past member of the Fort Smith Girls Club board.

Dr. McEwen is survived by his wife, Anne Stodder McEwen; one son, Fred J. McEwen of Fort Smith; one daughter, Kelsey Alexander of Custer, S.D.; and three grandchildren. ■



## Arkansas Medical Society's Physician's Legal Guide

Be one of the first to obtain this guide which contains a multitude of state and federal laws affecting the practice of medicine. This guide is a valuable resource for physicians, clinic and hospital administrators, office staff, attorneys, regulators and many others.

**\$65.00\***  
for AMS members  
**\$87.00\***  
List Price  
Prices include shipping and handling.

Check enclosed in the amount of: \$\_\_\_\_\_

Please charge my Visa or Mastercard:

☐ Please check if you are an AMS member.

Cardholder's name: \_\_\_\_\_

Credit card No.: \_\_\_\_\_ Exp. date: \_\_\_\_\_

Cardholder's Signature: \_\_\_\_\_

Name: \_\_\_\_\_

Clinic: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Fax No.: ( ) \_\_\_\_\_

CREDIT CARD ORDERS CAN BE FAXED TO: (501) 224-6489

Call the AMS office at 501-224-8967 or 800-542-1058 for volume discount pricing.

# ADVERTISERS INDEX

AMS Benefits Inc. ....	152
Arkansas Financial Group Inc., The .....	150
Arkansas Foundation for Medical Care .....	Inside front cover
Asti, William Henry, AIA .....	149
Central Flying Service .....	151
Emcare .....	162
Farmers Healthcare Professional Liability .....	148
Guesthouse Inn .....	151
HealthLink of Arkansas .....	171
Hutchinson/Ilfrah Financial Services Inc. ....	159
Little Rock Medical Association .....	172
Maggio Law Firm .....	159
Mary Healey's Fine Jewelry .....	147
Medical Protective Co., The .....	146
Metropolitan Investment Professionals .....	147
PhyAmerica Physician Services Inc. ....	150
Professionals Advocate Insurance Co. ....	Inside back cover
Regions Bank .....	162
Smith Capital Management .....	171
Snell Prosthetic & Orthotic Laboratory .....	Back cover
St. Vincent Health System .....	149
State Volunteer Mutual Insurance Co. ....	144

Special Publications  
Publisher  
*Brigette Williams*

Special Publications  
Editor-in-Chief  
*Natalie Gardner*

Assistant Editor  
*Christy L. Smith*

Sales Manager  
*Stephanie Hopkins*

Account Executive  
*Liz Earlywine*

Director of Design &  
Circulation  
*Virgeen Healey*

Director of Marketing  
*Allison Pickell*

Production and  
Circulation Coordinator  
*Jeremy Henderson*

Editorial Art Director  
*Irene Forbes*

Advertising Art Director  
*Matt Stewart*

Advertising Coordinator  
*Kristen Heldenbrand*

Marketing Assistant  
*Mitzi Tiffie*

Database Administrator  
*H.L. Moody*



**ARKANSAS BUSINESS  
PUBLISHING GROUP**

Chairman & Chief Executive Officer  
*Olivia Farrell*

President and Publisher  
*Jeff Hankins*

Executive Vice President  
*Sheila Palmer*

© 2000 Arkansas Business Publishing Group  
www.abpg.com

## Statement of Ownership, Management, and Circulation

United States Postal Service

### Statement of Ownership, Management, and Circulation

1. Publication Title <b>THE JOURNAL OF THE ARKANSAS MEDICAL SOCIETY</b>		2. Publication Number <b>0 2 8 3 - 8 6 0 0</b>		3. Filing Date <b>09-30-00</b>	
4. Issue Frequency <b>Monthly</b>		5. Number of Issues Published Annually <b>12</b>		6. Annual Subscription Price <b>\$30.00</b>	
7. Complete Mailing Address of Known Office of Publication (Not printed) (Street, city, county, state, and ZIP+4) <b>#10 Corporate Hill Dr., Suite 300 Little Rock, AR 72205</b>				Contact Person  Telephone	
8. Complete Mailing Address of Headquarters or General Business Office of Publisher (Not printed) <b>#10 Corporate Hill Dr., Suite 300 Little Rock, AR 72205</b>					
9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor (Do not leave blank)					
Publisher (Name and complete mailing address) <b>Arkansas Medical Society #10 Corporate Hill Drive, Suite 300 Little Rock, AR 72205</b>					
Editor (Name and complete mailing address)					
Managing Editor (Name and complete mailing address) <b>Judy Hicks, Communications Coordinator #10 Corporate Hill Dr., Suite 300 Little Rock, AR 72205</b>					
10. Owner (Do not leave blank. If the publication is owned by a corporation, give the name and address of the corporation immediately followed by the names and addresses of all stockholders owning or holding 1 percent or more of the total amount of stock. If not owned by a corporation, give the names and addresses of the individual owners. If owned by a partnership or other unincorporated firm, give its name and address as well as those of each individual owner. If the publication is published by a nonprofit organization, give its name and address.)					
Full Name <b>Arkansas Medical Society</b>		Complete Mailing Address <b>#10 Corporate Hill Drive, Suite 300 Little Rock, AR 72205</b>			
11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities. If none, check box <input checked="" type="checkbox"/> None					
Full Name		Complete Mailing Address			
12. Tax Status (For completion by nonprofit organizations authorized to mail at nonprofit rates) (Check one) The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes: <input checked="" type="checkbox"/> Has Not Changed During Preceding 12 Months <input type="checkbox"/> Has Changed During Preceding 12 Months (Publisher must submit explanation of change with this statement)					

13. Publication Title <b>THE JOURNAL OF THE ARKANSAS MEDICAL SOCIETY</b>		14. Issue Date for Circulation Data Below <b>July/August 2000</b>	
15. Extent and Nature of Circulation		Average No. Copies Each Issue During Preceding 12 Months	
a. Total Number of Copies (Net press run)		4495	
(1) Paid/Requested Outside-County Mail Subscriptions Stated on Form 3541, (Include advertiser's proof and exchange copies)		2877	
b. Paid and/or Requested Circulation		0	
(2) Paid In-County Subscriptions (Include advertiser's proof and exchange copies)		0	
(3) Sales Through Dealers and Carriers, Street Vendors, Counter Sales, and Other Non-USPS Paid Distribution		0	
(4) Other Classes Mailed Through the USPS		0	
c. Total Paid and/or Requested Circulation (Sum of 15b, (1), (2), (3), and (4))		2877	
d. Free Distribution Outside the Mail (Carriers or other means)		1441	
e. Total Free Distribution (Sum of 15d, and 15e.)		1441	
f. Total Distribution (Sum of 15c. and 15f.)		4318	
g. Copies not Distributed		177	
h. Total (Sum of 15g. and h.)		4495	
i. Percent Paid and/or Requested Circulation (15c. divided by 15g. times 100)		67%	
16. Publication of Statement of Ownership <input checked="" type="checkbox"/> Publication required. Will be printed in the <b>November 2000</b> issue of this publication.		<input type="checkbox"/> Publication not required.	
17. Signature and Title of Editor, Publisher, Business Manager, or Owner <i>Judy Hicks, Communications Coordinator</i>		Date <b>9/19/00</b>	

### Instructions to Publishers

- Complete and file one copy of this form with your postmaster annually on or before October 1. Keep a copy of the completed form for your records.
- In cases where the stockholder or security holder is a trustee, include in items 10 and 11 the name of the person or corporation for whom the trustee is acting. Also include the names and addresses of individuals who are stockholders who own or hold 1 percent or more of the total amount of bonds, mortgages, or other securities of the publishing corporation. In item 11, if none, check the box. Use blank sheets if more space is required.
- Be sure to furnish all circulation information called for in item 15. Free circulation must be shown in items 15d, e, and f.
- Item 15h, Copies not Distributed, must include (1) newspaper copies originally stated on Form 3541, and returned to the publisher, (2) estimated returns from news agents, and (3), copies for office use, leftovers, spoiled, and all other copies not distributed.
- If the publication had Periodicals authorization as a general or requester publication, this Statement of Ownership, Management, and Circulation must be published; it must be printed in any issue in October or, if the publication is not published during October, the first issue printed after October.
- In item 16, indicate the date of the issue in which this Statement of Ownership will be published.
- Item 17 must be signed.

Failure to file or publish a statement of ownership may lead to suspension of Periodicals authorization.

PS Form 3526, September 1998 (Reverse)





Photos: McRush Communications

## Beckham Creek Cave Haven

Ever wanted to spend the night in a cave? Why not do it the luxurious way? Beckham Creek Cave Haven, in the Buffalo National River country near Jasper, offers guests a truly unique getaway — in a living Ozark cave. Each room at this secluded resort features natural cave walls and ceilings. The getaway has been featured on “Lifestyles of the Rich and Famous with Robin Leach,” “NBC Nightly News,” and Home and Garden TV and in magazines, including *People*, *National Geographic* and *Four States Living*.

Beckham Creek Cave features five bedrooms, each with private bathrooms with bidets. With 5,500 square feet of living space, 10 people could share the space with plenty of room to breathe. The cave is not a bed and breakfast, therefore guests and their family and friends have the run of the place. The cost is \$300 per night, with \$75 for each additional guest. For 10 people, the cost per night is \$900. Discounts are given for stays more than one night.

The 2,000-square-foot Great Room features a natural waterfall and special lighting to help view the cave’s stalactites. The kitchen is fit for gourmet cooking, while the game room has a pool table with a view. Even the hot tubs in three of the bathrooms are set in natural rock formations. Horseback riding, hiking trails, swimming and fishing are available on the cave’s 530 scenic acres. There’s even a heliport for those who want to fly in for their vacation.

And for those who want to leave the comfort of the cave for a while, Eureka Springs is only 43 miles away, while Fayetteville is 72 miles away and Branson, Mo., is an hour’s drive. ■

*Beckham Creek Cave Haven, H C 72 Box 45, Parthenon, AR 72666. For information, call (870) 446-6045, (888) 371-CAVE or visit [www.ozarkcave.com](http://www.ozarkcave.com).*



In your job every decision is

CRUCIAL

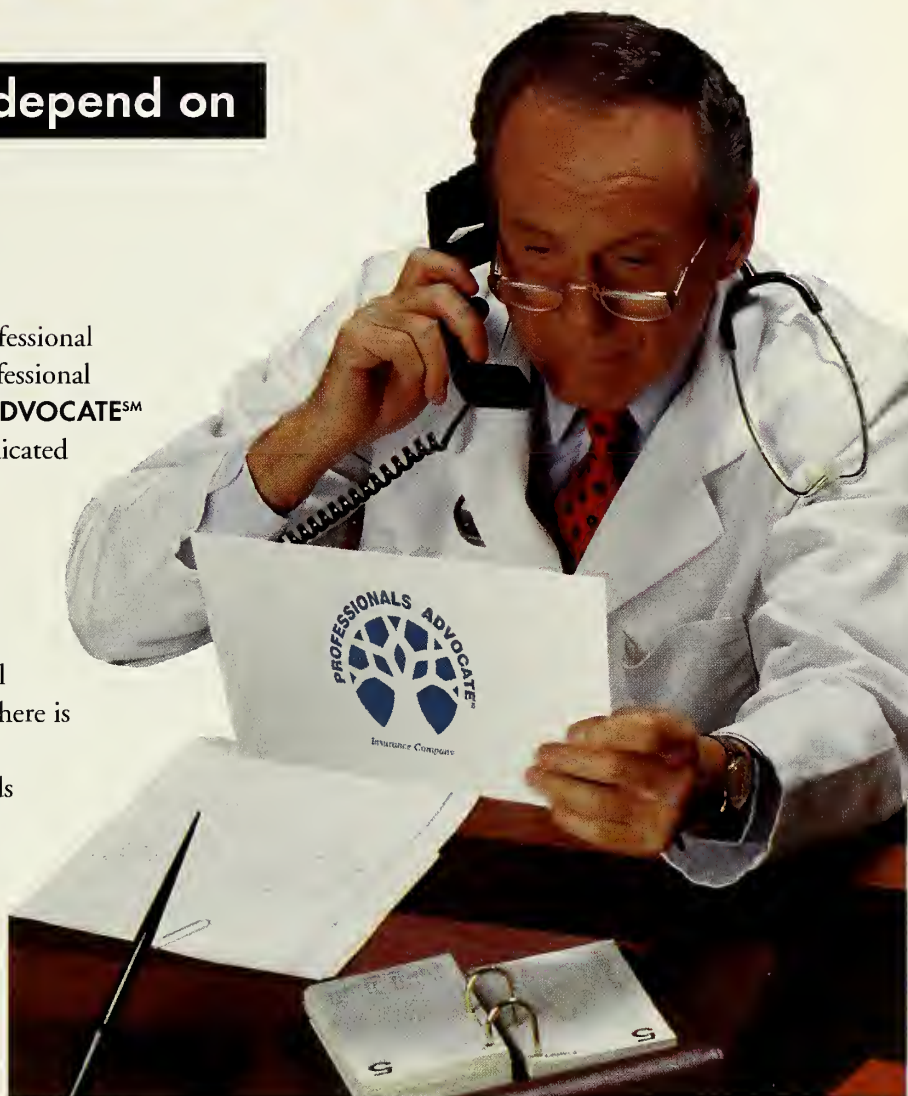
That's why you should depend on

## PROFESSIONALS ADVOCATE<sup>SM</sup>

If you want to make the right choice for your professional liability insurance, start by choosing the right professional liability insurance company. **PROFESSIONALS ADVOCATE<sup>SM</sup> (ProAd)** is a physician-owned liability insurer dedicated to the long-term defense of your career.

**ProAd** was founded by one of the oldest and most respected physician-owned and directed liability insurance companies in the country. This legacy gives us a solid foundation of financial resources, stability and experience. And, because there is direct physician involvement in the decisions that affect you, we are sensitive to the special needs of physicians and have a genuine commitment to protecting your reputation and practice.

Let **ProAd** be your advocate. Call today for additional information and a no-obligation quotation from a **ProAd** Agent conveniently located near you.



## The ProAd Advantage

- Quality coverage for all specialties at competitive prices from a financially stable physician-owned insurer.
- Free Tail coverage upon your full retirement with no age requirement, following one full year of continuous claims-made coverage with **ProAd**.
- Absolute Consent to Settle provision.
- New Practitioner discount.
- Full Prior Acts Coverage available.
- Aggressive claims defense policy. Top local attorneys specializing in medical malpractice defense.
- Defendant's reimbursement coverage. All covered attorney fees and defense-related expenses associated with the investigation paid by **ProAd**.
- Prompt and responsive service.
- Knowledgeable local agents selected for their health care expertise.
- MedGuard Defense Coverage with a limit of \$25,000 for defense of administrative or judicial proceedings included at no additional charge.



**Professionals Advocate<sup>SM</sup>**

[www.weinsuredocs.com](http://www.weinsuredocs.com)

Arkansas Agent: Rebsamen Insurance  
1500 Riverfront Drive, P.O. Box 3198  
Little Rock, AR 72203  
501-661-4800 • 501-666-9592 Fax



Now Open in Jonesboro.

*Pledging commitment is one of the most important things that human beings can do for one another. It means I'll do only my best for you. I'll fight for your rights. I'll be there for you.*

*At Snell Laboratory we make that type of commitment to each of our patients. We dedicate ourselves to making them as comfortable and as mobile as possible. We give them back as much of their former life as we can.*

# A MATCH MADE IN HEAVEN.



*Our computer-aided design and manufacture (CAD/CAM) system makes so much more possible in creating custom-fit prostheses than ever before. And new lightweight, space age materials mean more for our patients with custom orthoses. So regardless of what responsibilities your*

*patients agree to in life, from going out to play to attending a special occasion, our commitment to comfort never waivers.*

*Snell Prosthetic and Orthotic Laboratory has been in business since 1911. We've said "I do" to our patients since day one.*



**SNELL**  
Prosthetic & Orthotic  
Laboratory

THE LATEST IN TECHNOLOGY. THE BEST IN CARE.

Offices located in Little Rock, Russellville, Fort Smith, Mountain Home, Fayetteville, Hot Springs, North Little Rock, and Jonesboro.

Little Rock (501) 664-2624 • Statewide Toll-free 1-800-342-5541

Founding Members of PrimeCare O&P Network - serving the southern United States.



# THE Journal

OF THE ARKANSAS MEDICAL SOCIETY

Vol. 97 No. 6

December 2000

\*\*\*\*\*MIXED ADC 640 S54 P8  
Health Sciences Library  
University of Maryland  
Acquisitions/Serials Dept.  
601 W LOMBARD ST  
BALTIMORE MD 21201-1512

RS/HSL  
UNIVERSITY OF MARYLAND AT  
BALTIMORE  
NOV 22 2000  
STACKS  
REC'D NOT IN CIRC.

## Big City vs. Small Town Practices: Weighing the Benefits of Both



In your job every decision is

# CRUCIAL

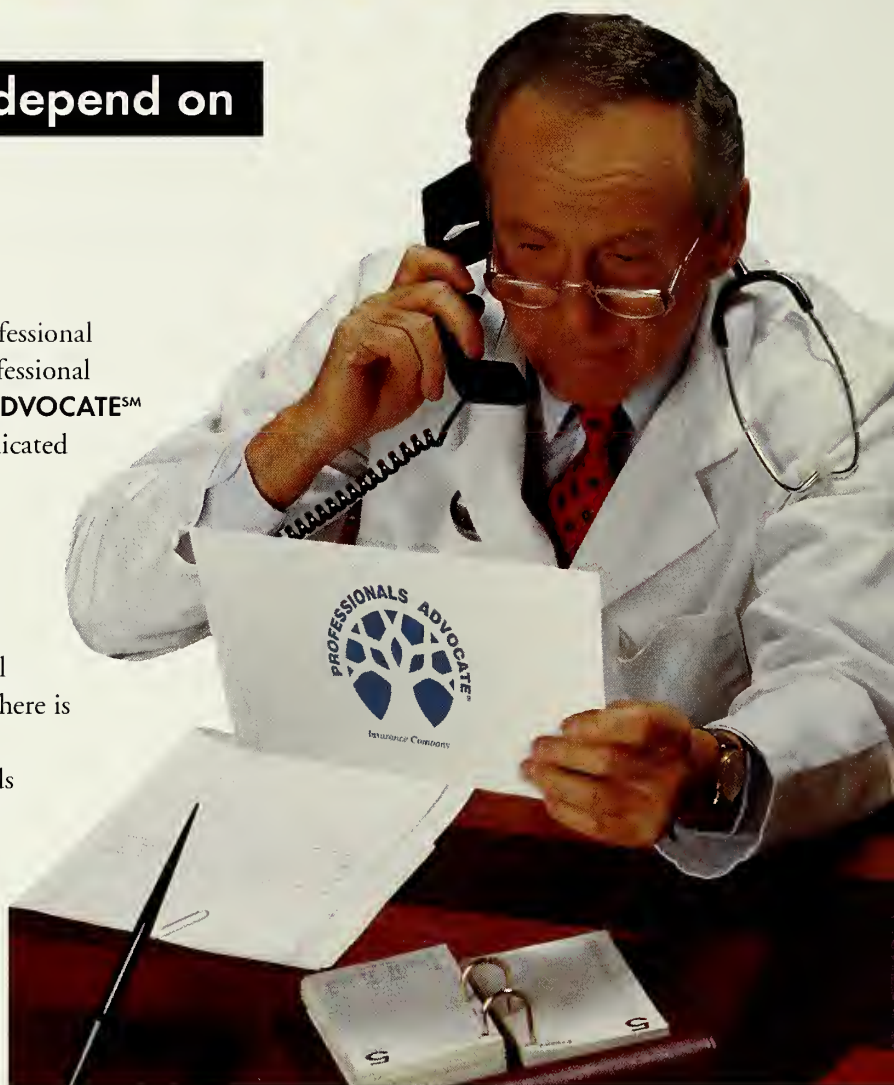
**That's why you should depend on**

## PROFESSIONALS ADVOCATE<sup>SM</sup>

If you want to make the right choice for your professional liability insurance, start by choosing the right professional liability insurance company. **PROFESSIONALS ADVOCATE<sup>SM</sup> (ProAd)** is a physician-owned liability insurer dedicated to the long-term defense of your career.

**ProAd** was founded by one of the oldest and most respected physician-owned and directed liability insurance companies in the country. This legacy gives us a solid foundation of financial resources, stability and experience. And, because there is direct physician involvement in the decisions that affect you, we are sensitive to the special needs of physicians and have a genuine commitment to protecting your reputation and practice.

Let **ProAd** be your advocate. Call today for additional information and a no-obligation quotation from a **ProAd** Agent conveniently located near you.



## The ProAd Advantage

- Quality coverage for all specialties at competitive prices from a financially stable physician-owned insurer.
- Free Tail coverage upon your full retirement with no age requirement, following one full year of continuous claims-made coverage with **ProAd**.
- Absolute Consent to Settle provision.
- New Practitioner discount.
- Full Prior Acts Coverage available.
- Aggressive claims defense policy. Top local attorneys specializing in medical malpractice defense.
- Defendant's reimbursement coverage. All covered attorney fees and defense-related expenses associated with the investigation paid by **ProAd**.
- Prompt and responsive service.
- Knowledgeable local agents selected for their health care expertise.
- MedGuard Defense Coverage with a limit of \$25,000 for defense of administrative or judicial proceedings included at no additional charge.



**Professionals Advocate<sup>SM</sup>**

[www.weinsuredocs.com](http://www.weinsuredocs.com)

Arkansas Agent: Rebsamen Insurance  
1500 Riverfront Drive, P.O. Box 3198  
Little Rock, AK 72203  
501-661-4800 • 501-666-9592 Fax

Some dealer's waiting list is two years...

Ours is more  
like two  
days.



HONDA S2000

MERCEDES-BENZ S430



At Autoflex Leasing,  
hard to find cars are  
our specialty.

Whether it's a Mercedes S500 or S430, the CLK Cabriolet or all new Honda S2000, your "hard to find" car could be just a phone call away. After all, your patients don't like waiting...Why should you?

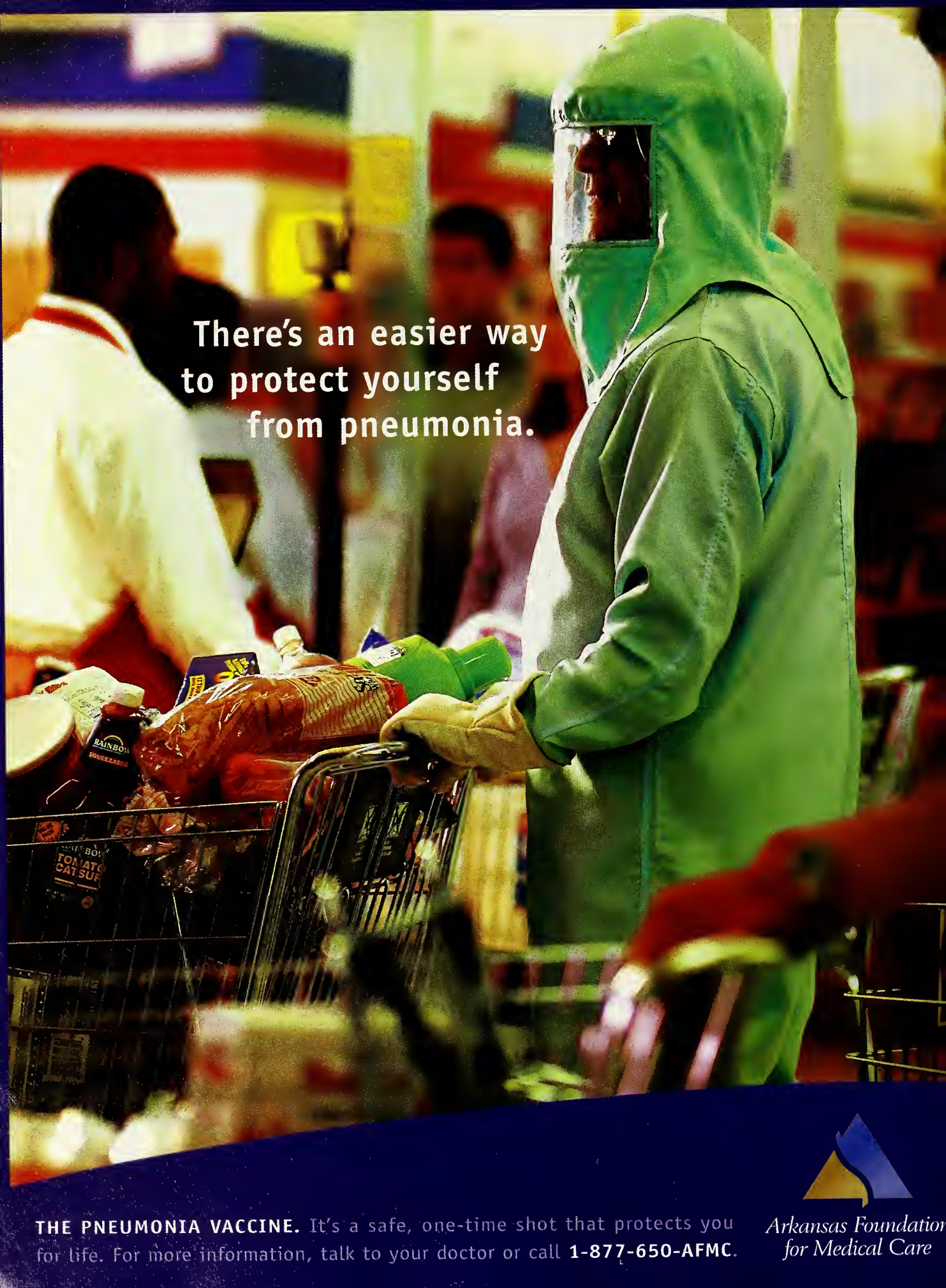


**Autoflex**  
L E A S I N G

**1-888-234-1234**

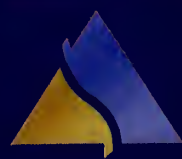




A person wearing a full-body white protective suit, including a hood and a clear face shield, is pushing a shopping cart through a grocery store. The cart is filled with various items, including a large bag of chips, a bottle of dish soap, and a box of tomato catsup. In the background, other shoppers are visible, but they are out of focus. The scene is brightly lit, typical of a grocery store.

There's an easier way  
to protect yourself  
from pneumonia.

**THE PNEUMONIA VACCINE.** It's a safe, one-time shot that protects you for life. For more information, talk to your doctor or call **1-877-650-AFMC.**



*Arkansas Foundation  
for Medical Care*



# CONTENTS

## FEATURES

**189 Is the Big City Life Good for Everyone?**

*Fewer than 11% of the nation's physicians practice in rural areas, where the pay is smaller and the hours longer. But small-town life offers many rewards that cannot be measured in dollars and cents.*

**192 Fighting for AMS**

*Michael W. Mitchell has served as general counsel for AMS for nearly 25 years. Much of his legal practice now focuses on managed care issues that interfere with the physician-patient relationship.*

**202 Serial Troponin I Measurements Detect Recurrent Myocardial Infarction After Initial Acute Myocardial Infarction**

*Dr. Hani Razek of UAMS' department of internal medicine and division of cardiology and two colleagues conducted a retrospective, pilot study of serial serum cardiac Troponin I and CK-MB measurements of 36 patients. Here, the researchers give a report on their findings.*

## DEPARTMENTS

**185 Commentary**  
*Carlton Chambers, MD*

**187 Letters to the Editor**

**188 What We've Done**  
*For You Lately*

**194 Loss Prevention**

**196 Cardiology Report**

**200 State Health Watch**

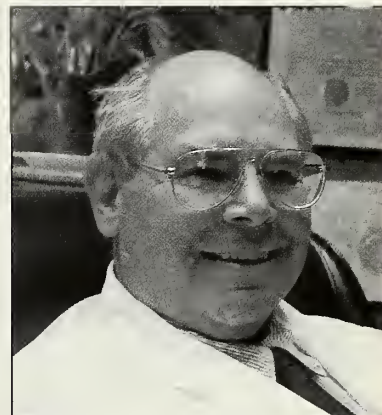
**205 People + Events**

**207 Membership Listing**

**225 Index to Advertisers**

**226 Arkansas Retreats**

*Cover Photos: Kirk Jordan*

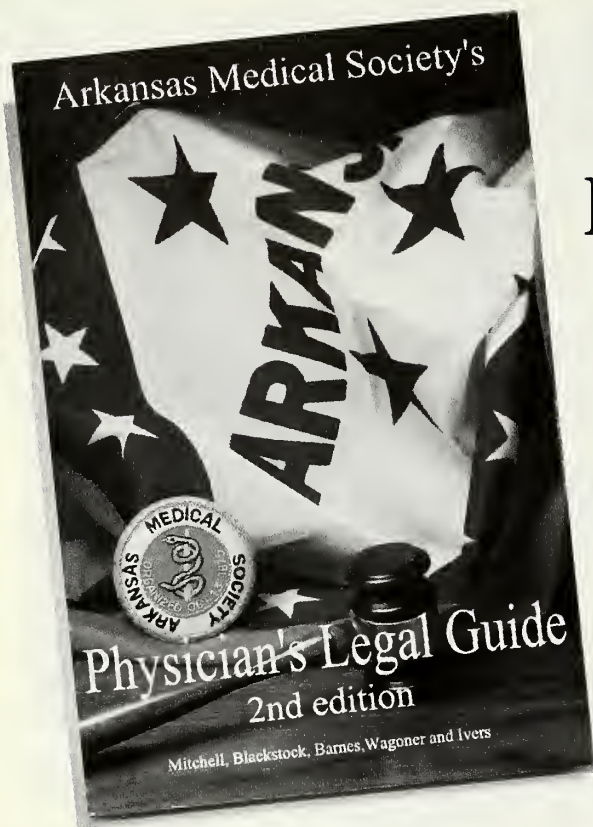


*Dr. Hamilton Hart of Fayetteville compares big-city and small-town medical practices.*  
— page 189



*Attorney Michael W. Mitchell defends the interests of AMS' members.*  
— page 192





## 2nd edition Arkansas Medical Society's Physician's Legal Guide

Be one of the first to obtain this guide, which contains many state and federal laws affecting the practice of medicine. This guide is a valuable resource for physicians, clinic and hospital administrators, office staff, attorneys, regulators and many others.

**\$87<sup>00</sup>** List Price  
**\$65<sup>00</sup>** for AMS members  
 A 25% Discount!  
 (Prices include shipping and handling.)

Call the AMS office at (501) 224-8967 or (800) 542-1058 for volume discount pricing.

☐ Please check if you  
are an AMS member.

☐ Check enclosed in the amount of: \$ \_\_\_\_\_

☐ Please charge my Visa or Mastercard: \$ \_\_\_\_\_  
 Credit card orders can be faxed to (501) 224-6489

Cardholder's name: \_\_\_\_\_

Credit card No.: \_\_\_\_\_ Exp. date: \_\_\_\_\_

Cardholder's Signature: \_\_\_\_\_

Name: \_\_\_\_\_

Clinic: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: (    ) \_\_\_\_\_ Fax No.: (    ) \_\_\_\_\_

COMMUNICATIONS COORDINATOR  
Judy Hicks

EXECUTIVE VICE PRESIDENT  
Kenneth LaMastus, CAE

ASSISTANT EXECUTIVE VICE PRESIDENT  
David Wroten

#### EDITORIAL BOARD

Jerry Byrum, MD	Pediatrics
Joseph M. Beck, II, MD	Oncology
Lee Abel, MD	Internal Medicine
Samuel Landrum, MD	Surgery
Jerry Kendall, MD	Family Practice
William Ackerman, MD	Anesthesiology

EDITOR EMERITUS  
Alfred Kahn Jr., MD

#### ARKANSAS MEDICAL SOCIETY 2000-2001 OFFICERS

Gerald A. Stolz, Jr., MD, Russellville  
*President*

Joe Stallings, MD, Jonesboro  
*President-elect*

Paul A. Wallick, MD, Monticello  
*Vice President*

Lloyd G. Langston, MD, Pine Bluff  
*Immediate Past President*

Carlton L. Chambers, III, MD, Harrison/Little Rock  
*Secretary*

Dwight M. Williams, MD, Paragould  
*Treasurer*

Anna Redman, MD, Pine Bluff  
*Speaker, House of Delegates*

Kevin Beavers, MD, Russellville  
*Vice Speaker, House of Delegates*

Joseph M. Beck, II, MD, Little Rock  
*Chairman of the Council*

Established 1890. Owned and edited by the Arkansas Medical Society and published under the direction of the Council.

**Advertising Information:** Contact Stephanie Hopkins, P.O. Box 3686, Little Rock, AR 72203; (501) 372-2816.

**Postmaster:** Send address changes to: *The Journal of the Arkansas Medical Society*, P. O. Box 55088, Little Rock, Arkansas 72215-5088.

**Subscription rate:** \$30.00 annually for domestic; \$40.00, foreign. Single issue \$3.00.

*The Journal of the Arkansas Medical Society* (ISSN 0004-1858) is published monthly by the Arkansas Medical Society, #10 Corporate Hill Drive, Suite 300, Little Rock, Arkansas 72205. Printed by The Ovid Bell Press, Inc., Fulton, Missouri 65251. Periodicals postage is paid at Little Rock, Arkansas, and at additional mailing offices.

Articles and advertisements published in *The Journal* are for the interest of its readers and do not represent the official position or endorsement of *The Journal* or the Arkansas Medical Society. *The Journal* reserves the right to make the final decision on all content or advertisements.

Copyright 2000 by the Arkansas Medical Society.

# DAVID YURMAN



## The Blue Ice Collection™

Blue Chalcedony & Diamonds in 18k Gold and Sterling Silver

## MARY HEALEY'S FINE JEWELRY

*Because You Love the Best*

5600 Kavanaugh • Little Rock, AR 72207

501-661-1314 • 501-661-9368 Fax

Mon - Sat 10 am - 5:30 pm

© COPYRIGHT D. YURMAN 2000

There are plenty of full service banks.  
So where are all the full service bankers?

If you want the type of personal service that's missing from most full service banks these days, call Metropolitan National Bank's Professional Banking Group. Our highly specialized team, led by Senior Vice President George Penick (978-7632), focuses exclusively on helping those with substantial assets, but limited time to maximize their potential.

Just make the SimpleSwitch to our Professional Banking Group at Metropolitan. We'll give you the personal service you've been looking for.



## Metropolitan National Bank

Little Rock, North Little Rock, Sherwood,  
Benton, Bryant and Conway

N E A R B Y & N E I G H B O R L Y.

www.metbank.com

Member FDIC





Two of the best financial planners in the nation are in Arkansas.

They can be found at The Arkansas Financial Group.

Since 1985, we've been helping busy people make smart financial decisions. So next time you're looking for objective answers to life's crucial financial decisions, call The Arkansas Financial Group. You'll be in great company.

Here's what the editors of *Worth* and *Medical Economics* had to say:

*"The Best 150 Financial Advisers for Doctors, 8/00"*

*"The Best 250 Financial Advisers, 9/99"*

*"The Best 300 Financial Advisers, 9/98"*

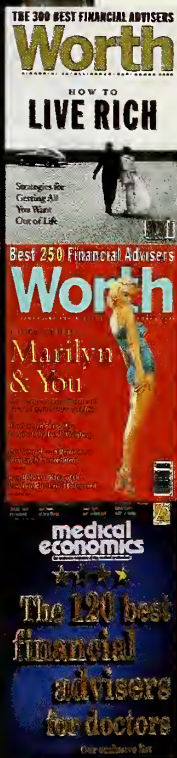
*"The Best 250 Financial Advisers, 10/97"*

*"The 120 Best Financial Advisers for Doctors, 7/27/98"*

*"Fee-only, objective, customized, comprehensive, affordable advice"*

**The Arkansas  
Financial Group, Inc.  
376-9051**

PHOTO: KELLY QUINN/TERRITORIAL RESTORATION



**CINDY CONGER**  
MBA, CPA/PFS, CFP

**RICK ADKINS**  
MBA, CFP, ChFC

Increase your heart rate without ever breaking a sweat



**HUMMER®**

- NO LUXURY TAX
- WRITE OFF 70% IN

TAXES FOR THE FIRST  
THREE YEARS.

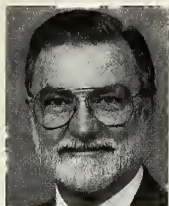
*Fiser*  
**HUMMER®**

www.fiser.com

501.847.9043  
1.800.776.4069







# "Knee-Jerk" Docs

CARLTON L. CHAMBERS III, MD

It has occurred to me that as we move more and more into the realm of managed care as the mechanism for rationing health care resources, we have forced many (if not most) physicians to change operating habits. A few of these changes have been for the good, but many are to the detriment of the patient, and therefore to the profession.

The requirement for us to see more patients per hour for economic reasons is not healthy for the patient or for us. In days long past there were times when the physician was so overworked that he had to short patients of their needed time and attention. And of course there were, and always will be, those individuals who choose to see patients too quickly for their own pecuniary benefit. It seems, however, that now all physicians are forced into a pattern of too-rapid patient care.

This rapid-fire churning of patients often results in the type of care I refer to as "knee-jerk" care. A typical scenario:

After receiving a contract-man-dated appointment within 48 hours of calling the primary care physician's office, the patient arrives on time and is presented with a stack of forms to fill out. Halfway through completing the oft-redundant questions she is hurried into an exam room to comply with the contract-required 30-minute waiting time. Asked to disrobe and wait, she shivers to complete the questionnaires. After an arguably too-long wait the harried physician arrives thumbing through the proffered forms and gets to hear the patient's chief complaint quickly followed by a couple of questions.

A very quick inspection of the affected part is followed by a rapid diagnosis, and the expected prescription is prepared. The physician leaves the

room to finish checking off the blanks so that the computer program can type out a beautiful form complete with histories, complete physical exam report and diagnostic codes, etc. This results in a beautiful, level four, office visit report with the appropriate charges.

This is a "knee-jerk" office visit. The basis for the care was a very short history, quick physical exam and a "street car" level of diagnosis that often requires very little of the true physician skills we suffered through medical school to develop.

This "knee-jerk" doctor is in stark contrast to the physician who entertains the patient's history, does a proper examination and then attempts to educate the patient of her disorder, recommend life changes and appropriate medications to enhance her life.

We as physicians have allowed the bean-counter — and others whose prime concern is with the accountant rather than the patient — to dictate to us the manner in which we will perform our duties. In so doing we are falling into the trap being laid for our own demise. When patient visits can be reduced to symptom-to-prescription connections there will be no need for true medical training, and we will be replaced by nurses, technicians or others who strongly desire to "play doctor" without the deep responsibilities taught by proper medical training. We must resolve to keep the best interest of each patient foremost in our minds to honor the respect we have been given, and to provide the best care our patients deserve to receive. Any less is a betrayal of our vows.

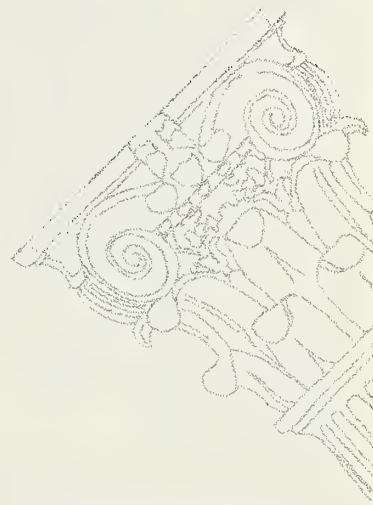
Which will you be? Physician or "knee-jerk" doc? ■

*Dr. Chambers is secretary of the AMS and an otolaryngologist in Little Rock.*

## ARCHITECTURE

FOR YOUR MEDICAL NEEDS

1 800 764 ASTI



William Henry Asti, AIA

architects, economists, development consultants

## ST. VINCENT HEALTH SYSTEM

### Hospitalist Opportunity

Actively searching for internist interested in serving in the exciting new specialty of full time hospital care.

If you have a interest or know someone interested in a hospitalist role, please contact Faye G. Stewart at St. Vincent Health System 501-660-3245 or 800-482-1288 ext. 3245.

† CATHOLIC HEALTH INITIATIVES

**St. Vincent Health System**

INTENSIVE CARING.

[www.stvincenthealth.com](http://www.stvincenthealth.com)



*Pledging commitment is one of the most important things that human beings can do for one another. It means I'll do only my best for you. I'll fight for your rights. I'll be there for you. At Snell Laboratory we*

*make that type of commitment to each of our patients. We dedicate ourselves to making them as comfortable and as mobile as possible. We give them back as much of their former life as we can.*

# A MATCH MADE IN HEAVEN.



*Our computer-aided design and manufacture (CAD/CAM) system makes so much more possible in creating custom-fit prostheses than ever before. And new lightweight, space age materials mean more for our patients with custom orthoses. So regardless of what responsibilities your*

*patients agree to in life, from going out to play to attending a special occasion, our commitment to comfort never waivers.*

*Snell Prosthetic and Orthotic Laboratory has been in business since 1911. We've said "I do" to our patients since day one.*



**SNELL**  
Prosthetic & Orthotic  
Laboratory

THE LATEST IN TECHNOLOGY. THE BEST IN CARE.

Offices located in Little Rock, Russellville, Fort Smith, Mountain Home, Fayetteville, Hot Springs, North Little Rock, and Jonesboro.

Little Rock (501) 664-2624 • Statewide Toll-free 1-800-342-5541

Founding Members of PrimeCare O&P Network - serving the southern United States.



## LETTERS

Aug. 27, 2000

I am responding to Dr. Lee Abel's commentary, "Brilliant Disguise," in the September 2000 *Journal*. I am relating my own experience. I believe it is a mistake to ever present an image to another person because you think that they expect it. It seems many times we fall vulnerable to this symptom of poor self-esteem.

Frankly, I suspect that many physicians, such as myself, emerge from their scientific training with an adolescent mindset. Because of this, it was difficult for me to relate in a human manner to my patients. I had bought into the lie, as Dr. Abel mentioned, that doctors should somehow present themselves as powerful, symbolic totems of healing and power. This could not be further from the truth. Physicians are ordinary people with all of the problems that everyone else has. It is when we doctors realize this and do not set ourselves apart that we begin to really develop effective skills as physicians.

I believe that everything I have learned since I have been practicing medicine has been directly learned from my patients, not from attending seminars, spending fellowships with experts and reading scientific literature. Medicine is an art and always will be an art. Communication is impossible if there is a lack of a certain amount of bonding between the patient and the physician. This may sound trendy, but I do believe that there is a certain amount of intimacy involved that many physicians fear

to face because of the persistence of their emotional immaturity which began in the cloistered environment of medical school. If your fear or ego blocks your ability to have no mask, then I feel sorry for you.

I believe that a physician's professional talents, skills, intuition and art are definitely on loan, so there is no need for a doctor to feel proud of his accomplishments but grateful for the opportunity to offer service. I do feel that medicine is a vocation just like the ministry, so look upon a career in medicine as an ego massage, and a self-retirement is to sell oneself short, and in effect spoil, the whole opportunity to be of real use to your fellows who suffer from disease.

Money has corrupted medicine, and the people in medicine, just like it, corrupts people in business and other professions. Money has no value. It has evidence of value, but essentially it is worthless except as a medium of exchange for material items.

Finally, Dr. Abel, if you really want to clean some dishes, put Credence Clearwater Revival on instead of Bruce Springsteen. Thanks for your provocative commentary and for stimulating me to think about this subject, which I feel is critical for our profession to grasp before we sell ourselves short without realizing what an opportunity we have to do good. ■

Sincerely,  
Joseph W. Matthews, MD  
Little Rock

Sept. 1, 2000

This is written in response to the conclusion written by J. Kelley Avery, MD, in the Loss Prevention article, "A Baseline is Necessary," from the September 2000 issue.

In a nutshell, an otherwise healthy 42-year-old woman with stress incontinence and uterine prolapse was treated with a routine vaginal hysterectomy and anterior and posterior repair. Postoperatively she was given between 5 and 6 liters of D5W (the article doesn't say how long a period of time was required to give this solution). The patient ended up dying apparently from "water intoxication resulting in severe hyponatremia." Dr. Avery concludes with the implication that what killed this lady was the surgeon's failure to obtain a preoperative electrolyte study. That conclusion is absurd. The problem here is that this poor lady was poisoned with water. I don't see how a preoperative electrolyte study would have made any

difference in light of the type and amount of fluids she was given.

In my orthopaedic practice, we have a loose protocol developed in conjunction with the anesthesiology department regarding preoperative testing. Routine electrolyte studies in a healthy 42-year-old woman are not required in our protocol nor are they needed. I don't think they were needed in the case described in the article. What was needed was an appropriate type and amount of postoperative IV fluid. Unless fluid and electrolyte physiology is drastically different in an OB/GYN patient from what it is in an orthopaedic patient, malpractice was committed here. I don't really think there's much of a loss prevention lesson in this article. What we have here is a doctor who needs to go back to medical school. ■

Sincerely,  
Scott S. Cooper, MD  
Rogers

## INFORMATION FOR AUTHORS

Original manuscripts are accepted for consideration on the condition that they are contributed solely to this journal. Material appearing in *The Journal of the Arkansas Medical Society* is protected by copyright. Manuscripts may not be reproduced without the written permission of both author and *The Journal of the Arkansas Medical Society*.

*The Journal of the Arkansas Medical Society* reserves the right to edit any material submitted. The publishers accept no responsibility for opinions expressed by the contributors.

All manuscripts should be submitted to Judy Hicks, Arkansas Medical Society, P.O. Box 55088, Little Rock, Arkansas 72215-5088. A transmittal letter should accompany the article and should identify one author as the correspondent and include his/her address and telephone number.

### MANUSCRIPT STYLE

Author information should include titles, degrees, and any hospital or university appointments of the author(s). All scientific manuscripts must include an abstract of not more than 100 words. The abstract is a factual summary of the work and precedes the article. Manuscripts should be typewritten, double-spaced, and have generous margins. Subheads are strongly encouraged. The original, one copy and the manuscript on a 3-1/4" diskette should be submitted. Pages should be numbered. Manuscripts and diskettes are not returned; however, original photographs or drawings will be returned upon request after publication. Manuscripts should be no longer than eight typewritten pages. Word count should not exceed 1,700. Exceptions will be made only under most unusual circumstances.

### REFERENCES

References should be limited to ten; if more than ten are listed, the author(s) may designate the ten most significant to be printed and readers will be referred to the author(s) for the complete list. References must contain, in the order given: name of author(s), title of article, name of periodicals with volume, page, month and year. References should be numbered consecutively in the order in which they appear in the text. Authors are responsible for reference accuracy.

### ILLUSTRATIONS

Illustrations should be professionally drawn and/or photographed. Glossy black and white photos are preferred. They should not be mounted and should have the name of the author(s) and figure number penciled lightly on the back. An arrow should indicate the top of the illustration. In photographs in which there is any possibility of personal identification, an acceptable legal release must accompany the material. Up to four illustrations will be accepted at no charge to the author(s). If more than four are necessary, it is understood that the author(s) will be responsible for the reproduction costs.

### REPRINTS

Reprints may be obtained from *The Journal* office and should be ordered prior to publication. Reprints will be mailed approximately three weeks from publication date. For a reprint price list, contact Judy Hicks at *The Journal* office. Orders cannot be accepted for less than 100 copies.



# Need to Brag?

**Let your peers  
& colleagues  
know:  
Top Flight  
Hospital  
Services,  
New Hires  
& Associates,  
Promotions,  
Honors &  
Awards.**

**THE  
Journal**  
OF THE ARKANSAS MEDICAL SOCIETY

**For Advertising Information,  
Contact Stephanie Hopkins  
501-372-2816 ext. 293.**

## WHAT WE'VE DONE FOR YOU LATELY



## Behind-the-Scenes Legal Work Provided to AMS Members

BY DAVID WROTEN

**L**et's face it: We all know a few good, or not so good, lawyer jokes. In this month's issue of *The Journal*, we are featuring an attorney for whom I have a great fondness, so I'm resisting the urge to begin this article with a few classics.

Michael Mitchell is the legal counsel for the Arkansas Medical Society. Most of the physicians who make up AMS have never met Mike, and most never will meet him. Those same physicians have most likely benefited from his legal knowledge even though they probably don't know in what way.

If you've ever called the Society for a legal question related to your practice, you probably have received a response from me, Ken LaMastus or maybe Lynn Zeno. Maybe it's a question about medical records, dismissing an unruly patient, managed care contract issues, patient confidentiality, compliance with the Americans with Disabilities Act or a host of other medical issues. The advice you received was most likely given only after careful discussion with Mike Mitchell.

Mike is one of only a handful of attorneys in Arkansas who have developed a certain specialization in medical issues. We put that knowledge to good use where it directly and indirectly benefits you. If you treat Medicaid patients, you have directly benefited from a 1992 lawsuit over Medicaid reimbursement. Mike and his associate, David Ivers, now one of Mike's partners, successfully tried what was to become a landmark case.

The AMS' *Physician's Legal Guide*, now in its second edition, was developed and written exclusively by Mike's law firm. It is the only publication of its kind for Arkansas physicians and one that every medical practice should own.

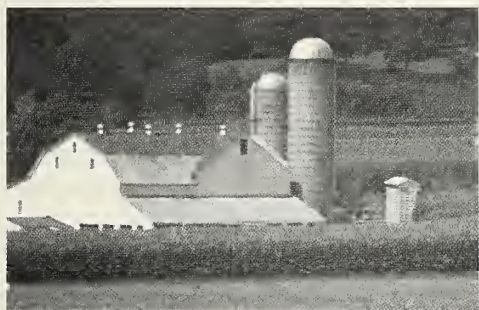
Like many attorneys, Mike is a lobbyist and a key player in AMS legislative affairs efforts. Working closely with Lynn Zeno, our director of governmental affairs, Mike plays a major role in our lobbying activities, and his firm routinely drafts language for our legislative and regulatory proposals, such as the Health Care Consumer Act and Patient Protection Act.

As a private attorney, Mike is obviously not an AMS employee. We do, however, consider him a member of our AMS family and a trusted friend and adviser to our staff, officers and membership. From Mike, you get more than legal advice, more than someone to write or review contracts. I have witnessed firsthand the respect and admiration Mike has for physicians and their patients.

As an AMS member, I thought you should know a little more about Mike and how he benefits your practice and your profession. It's not what have we done for you lately, but what your association does for you each day with the help of people like Mike Mitchell.

We're proud to feature Mike in this month's issue of *The Journal of the Arkansas Medical Society*. ■

# Is the Big City Life Good for Everyone?



*Many Arkansas physicians choose to practice in rural America, where the pay is smaller, the hours longer and life is more care-free.*

BY CHRISTY L. SMITH

**D**r. Charles Jackson has never received chickens as payment for services, but his patients often bring him jams, vegetables they've grown in their gardens and fishing lures to show their appreciation for his work.

"That happens pretty often in a small town. It's nice, really," he said.

The 31-year-old family physician has practiced at St. Joseph's Medical Clinic in Mount Ida, population 930, for three years. He said living in a large city has never been an option for him and his wife, both of whom grew up in small towns.

Living in a small town allows Dr. Jackson to fish, farm, garden and tend cattle, plus it offers a better atmosphere in which to raise his three children — Andy, 6, Matthew, 4, and Rusty, 18 months.

"That's part of why I ended up in this area," he said. "When I went through medical school and did my residency, I knew that we were both from smaller areas and don't like big cities. Where I live now, I'm eight miles from my office. When I drive to my office, I can count the number of cars I see on one hand. On a busy morning, you can count them on two."

But Dr. Jackson is in the minority. According to the National Rural Health Association, based in Kansas City, Mo., fewer than 11% of the nation's physicians practice in rural areas. The approximately 51 million Americans living in rural areas are in need of health care because they tend to have higher rates of poverty and infant mortality, as well as a denser

concentration of elderly patients, than urban residents, according to the association.

"Medical students are discouraged in both subtle and overt ways from entering primary care specialties and from practicing in underserved areas," Drs. Debra M. Phillips of Illinois and Philip G. Dunlap of Massachusetts pointed out in a November 1998 association issue paper, "Physician Recruitment and Retention." Less pay, longer working hours and fewer job prospects for spouses accompanying physicians to rural areas are just a few of the reasons physicians do not set up practice in rural areas, said Drs.

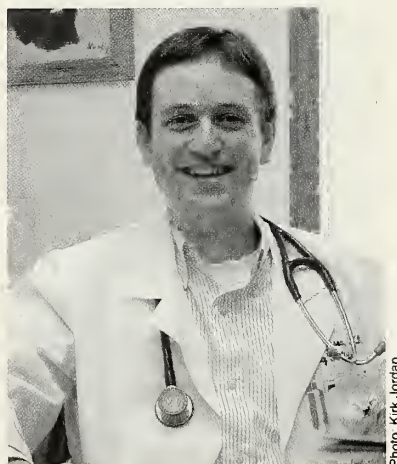
Phillips and Dunlap.

Dr. Jackson agreed it's hard to recruit physicians to rural areas. He has been the only doctor practicing at the two-man St. Joseph's Mount Ida Medical Clinic for two years. One entire wing of the clinic stands unused, he said.

"We've had five or six doctors come here and then go to another place like Mena. One thing that probably deters doctors from practicing in a small town is that you can make more money in a larger city. There's no doubt about it. There's a big difference financially," he said.

But Dr. Jackson said he wouldn't trade his small-town life for the hubbub of a big city, even though he works long hours and cannot hide from his patients.

"Here, you can't avoid patients. People know where I live. People call me at home. They show up on my front



Charles Jackson, MD

Photo Kirk Jordan



steps. I can't go anywhere without seeing somebody I know. I can't think of a single place where I can go hide here. But we like the lifestyle a small town offers," he said.

### Fleeing Rural America

Dr. William F. Joseph, who hails from the 4,300-person Walnut Ridge, grew up the son of a small-town doctor. The 44-year-old family practice physician said he remembers well the disappointment of sharing his father with patients during family times.

"It was not uncommon for us to be eating supper, and a patient would come to the house," he said. "I remember one Christmas morning when he had to go to the hospital. We couldn't even complete opening our Christmas gifts."

The Joseph family eventually began excepting those incidents without question, and oftentimes postponed their holiday celebrations until the family patriarch returned from his call, Dr. Joseph said.

"We didn't question it. He just went upstairs and came back down dressed, and my mother said, 'Kids, daddy has to go to the hospital. Let's play with these toys and when he gets back, we'll see what else Santa Claus brought,'" he said.

But that's the kind of life Dr. Joseph said he did not want for his four children — Eric, 13, Zack, 11, Alex, 4, and Lauren, 2. So, after finishing his residency in 1985, Dr. Joseph established his practice at St. Vincent Family Clinic in Little Rock.

"This affords me the opportunity to have a high-quality practice with technology. I can provide high quality for my patients and have a very stimulating professional environment, but yet at the end of the day when I go home, I get to be a husband and a father and do the things that small-town doctors don't have the luxury of doing," he said.

According to the Federal Office of Rural Health Policy, physicians in small towns spend as much as 16% more time per week in direct patient care and have 38% more patient visits per week than their metropolitan counterparts.

Dr. Joseph said he sees 25-30 patients per day, works a normal, eight-hour day four days each week, and has no hospital duty.



William Joseph, MD

Photo Kirk Jordan

But Dr. Richard Davis, a 43-year-old family practice physician at the Smackover Family Practice Clinic, generally works a 14-16-hour day, seven days a week. Plus, since he's the only practicing physician in Smackover, Dr. Davis is not immune to occasional drop-ins at his home, he said.

"One of the unique things about being in a small town is if somebody's having an acute problem, they'll come by my house to get me," Dr. Davis said. "If I don't see those people, there's no one else in the community who can handle medical problems. In small-town medicine, you are on the front line. A lot of times you have to handle some problems rather acutely in the clinic until you can get that person stabilized to get them to the specialty care they need."

Originally from North Little Rock, Dr. Davis said he moved to a small town 15 years ago because the environment is more conducive to raising a family. Smackover was especially appealing because of its proximity to a larger town, El Dorado, which is only 20 miles away.

"I was looking for a smaller town closer to a large town so that I could be involved in a large-town call schedule," he said.

### Rural Medicine Benefits

Practicing medicine in a rural area has its own unique set of features.

More than 51 million Americans live outside metropolitan areas, defined by the U.S. Office of Management and Budget as a community of at least 50,000

residents, according to the National Rural Health Association.

Those rural residents tend to be "older, poorer, sicker, less educated" than their urban counterparts, according to the association. Plus, rural residents have a higher rate of infant and injury-related mortality, fewer hospital beds and are less likely than urban residents to have health insurance.

Dr. Davis concedes managed care hasn't caused much of a stir in rural south Arkansas.

"South Arkansas doesn't have a large amount of managed care. It hasn't hit us as hard as other places. The majority of patients are fee-for-service," he said.

That's because rural communities lack the economic base to support large employers; who are more likely than small businesses to provide their employees with health coverage, said Dr. Hamilton Hart of Fayetteville.

"Managed care is a product of an employer, and if you are self-employed in a rural area, you are not going to have managed care available to you," said the 59-year-old family practice physician.

During the 1960s, Dr. Hart was stationed at Memphis in the Navy. He said that during his stint in the military, he "moonlighted" at a clinic in Forrest City, a small city of about 13,000. Since establishing his practice in Fayetteville, population 58,163, in 1971, he has witnessed firsthand the affect managed care can have on the well-being of patients, he said.

"Managed care probably has resulted in a lot of people getting better care," Dr. Hart said.

Patients have better screening for cancer and cardiac disease, monitoring for conditions such as diabetes and high blood pressure, and many patients have stopped smoking due to managed care's emphasis on smoking cessation, Dr. Hart said.

And managed care has promoted "continuity of service" by requiring the enrollee to choose a primary care physician, he said.

But there's no doubt that managed care is burdensome, said Dr. Joseph.

"In a more urban area, we are inundated with managed care,



formularies, things that increase the hassle factor. That's one thing that our compadres in small towns are not having to deal with to the degree that we are," he said.

### A Different Lifestyle

Physicians who practice in rural areas often develop close-knit relationships with the people in their communities, but the trade-off is that they tend to work without a strong network of specialist support, according to the National Rural Health Association.

And that's a trade-off Dr. Joseph was not willing to make, he said.

"The small-town communities are very homey, and you really feel like you're making a difference. In a city like Little Rock, you have anonymity and really very little influence. That same individual in a small town would be very active on the school board and in their church and in a variety of other areas. You're dramatically diluted down in the city. I miss the Friday night football games at Walnut Ridge High School, but it's just a trade-off," he said.

The lack of specialty support can be very taxing on a small-town physician who must handle all manner of emergencies and illnesses on his own, Dr. Hart added.

"It's very, very difficult to be everything to everyone, and the long hours and lack of sleep sometimes wear them down," he said.

Dr. Hart said when he began his practice in 1971, Fayetteville had only 25,000 people, five family practice physicians and five specialists. Today, the city has more than doubled in size, and there are more physicians and specialists than he can count.

"I've had so much help from all the specialists in town," Dr. Hart said. "Before, I had to handle pretty much everything by myself. It has made our lives so much easier. It's so much nicer to come to work feeling rested and feeling like you can function better. It's really the ideal way to practice — having somebody to help you."

Although practice styles differ in rural and urban settings, doctors in both areas deal with the same basic illnesses, Dr. Joseph said.

"We take care of the same types of problems that small town doctors do — bread-and-butter things like hypertension, diabetes, depression, upper respiratory infections," he said.

But access to care is a problem for many rural residents, Dr. Joseph said.

"In some of the rural areas, there's not the access to medical care that we have in a metropolitan area. You tend to see more in-stage problems that could have been prevented if those patients could have afforded medical care. In metropolitan areas, there tend to be more social-service resources available," he said.

Small-town doctors also tend to see more elderly patients than their big-city counterparts because they are juggling their clinic-based practices with nursing home and hospital work, he said.

"They don't have the luxury of having someone take care of their hospital patients for them," Dr. Joseph said.

But the lack of managed care, technology and specialist support in rural areas means that doctors practicing there have the opportunity to make a true difference in the lives of their patients, Dr. Davis said.

"In a small town, you are so close to your patients," Dr. Davis said.

"You know them personally, you know their families. When they are going through difficult times, you are going through difficult times, too. It's easier to feel the compassion you need to feel toward your patients when it's a personal friend."

Dr. Joseph said the thought of giving up that physician-patient closeness nagged at him when he was trying to decide whether to establish his practice in Little Rock.

"That was a real difficult decision because I role-modeled after my father. There's no question from a quality-of-life standpoint, if you like small towns, that's a fabulous way to give back to the community. It's a fabulous way to feel like you are an intimate part of the lives of your patients," he said. ■

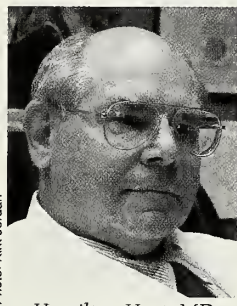


Photo: Kirk Jordan

Hamilton Hart, MD

## Recruiting for Rural Arkansas

The Community Match Student Loan and Scholarship Program was created by the Arkansas Legislature in 1995 to increase the number of primary care physicians in rural Arkansas.

Under the Community Match Program, qualified medical students at the University of Arkansas for Medical Sciences are paired with rural communities in need of a primary care physician.

### Medical student program is a win-win for everyone

The community pays up to \$16,500 per academic year to help students complete their medical studies, and in exchange the students promises to practice full-time primary care medicine in the contracting community for the same number of years they

received financial assistance.

According to the guidelines of the match program, a rural community is one with a population of less than 15,000, or one that has been deemed to be a "health professions shortage area" by the state Rural Medical Practice Student Loan and Scholarship Board. Forty-eight Arkansas communities have participated in the program since 1995. Among them are Corning, Piggott, Forrest City, Helena, Dermott, Magnolia, Mineral Springs, England, Perryville, Clinton and Harrison.

To date, about 70 UAMS graduates have been placed in rural communities through the match program, said Yvonne Lewis, associate director of education for the state Area Health Education Centers program.

The program hit a peak in 1998-99, when 23 medical school graduates were placed. Thirteen graduates participated in the 2000-2001 Community Match Program.

According to program guidelines, loan and scholarship recipients must be residents of Arkansas who are enrolled in a "medically underserved and rural practice curriculum" at UAMS; be a person of "good moral character" and possess the "talent and capacity to profit" from his medical studies; and be approved by a designated representative of a qualified rural community. Each student applicant is interviewed by the Rural Medical Practice Student Loan and Scholarship Board. ■



# Meet Our Attorney

## Michael W. Mitchell

By CHRISTY L. SMITH

Arkansas physicians have a friend in Michael W. Mitchell.

As general counsel for the Arkansas Medical Society, the 56-year-old attorney intervenes any time a third party threatens or interferes with the physician-patient relationship in Arkansas. He has written letters, filed lawsuits and attended regulatory hearings on behalf of the medical society.

"I've been called upon to do everything except ... sweep the floor," he said, joking.

Mitchell's law firm, Mitchell, Blackstock and Barnes of Little Rock, has represented the medical society for nearly 25 years, and recent changes in the medical field have fundamentally altered the nature of his work. While scope-of-practice issues occupied much of his time when he started representing AMS, managed care is Mitchell's No. 1 priority now.

### Medical Society Attorney Takes on Managed Care

"With a client such as the medical society, you're going to, by necessity, do a lot of continuing legal education in the area of health care law," he said.

Mitchell, the only son of four children, spent the first decade of his life in Pine Bluff. His family moved to Tyler, Texas, in the mid-1950s when his father, a Cotton Belt Railroad employee, was transferred to company headquarters.

Mitchell graduated from the University of Texas at Austin in 1966. He pursued a career in law at the urging of his father.

"He sized my personality up ... and felt like [law] was what I should do. So, I did it. Fortunately, he was right," Mitchell said.

He graduated from the School of Law at the University of Arkansas at Fayetteville in 1969 and immediately started a practice in Pine Bluff. Six years later, Mitchell partnered with some of his law school buddies

in Little Rock. That firm soon merged with a practice begun by "sage, venerable, mentoring lawyers" Eugene R. Warren and Judge Brooks Bullion, who had long since retired from the bench, Mitchell said.

Mitchell initially worked alongside Warren, representing AMS. He took over as general counsel in 1980 after Warren's death.

The issues Mitchell dealt with 20 years ago — Good Samaritan statutes, physician liability, medical malpractice and scope of practice — have given way to managed care problems such as physicians' rights, contractual matters and legislative issues, Mitchell said.

"Many things these days attack the physician-patient relationship, which is the core of what doctors do. Rather than the physician and the patient making decisions in the best interest of the patient, a third party has now interceded," Mitchell said.

And in some cases, third-party intervention can severely hinder a physician's ability to remain in practice, Mitchell said.

*When he is not addressing managed care issues for Arkansas physicians, Michael W. Mitchell enjoys spending time outdoors with his son, Michael Charles, 13.*



For instance, while the common consumer is expected to remit payment for a bill within 30 days, some insurance companies take as long as 120 days to pay a physician for his services, Mitchell said.

"They seem to have the power of the purse. They make the rules on when they pay. We recently had an issue before the Insurance Commission [questioning] the length of time that is proper for an insurance company to pay an acceptable claim," Mitchell said.

That issue has yet to be resolved.

"These things aren't resolved in a matter of days or even weeks. They are ongoing," he said.

It also is not uncommon for third-party providers to drop a physician from their plans when that physician encourages his patients to vigorously request that coverage be extended to treatments that are considered experimental, Mitchell said.

"Contractual issues between physicians and insurance companies are becoming more of an issue. Generally, Arkansas has always been an at-will employment state. So, can an insurance company for no reason cast aside a physician who is doing a good job [when he] advocates for patients to call and make a lot of noise about providing coverage?

"The insurance company gets irritated at this doctor because they don't want to hear the complaints, so they terminate his contract. The physician cannot see those patients anymore. They may have a huge percentage of his patients, so it could literally in one day affect his practice severely," he said.

Mitchell predicted this type of contractual dispute would continue to be a problem as managed care evolves. He said bills dealing with what he called the unfair practices of managed care entities would be debated in the state Legislature until the system was changed.

"The evolutionary process is slow, and, hopefully, [one day] we can look back and say that we have some sort of animal that's fairer to the doctor, fairer to the patient and fairer to the insurance company. You have those three interests that have to be

balanced," he said.

When he is not dealing with managed care and the many tasks assigned to him by the medical society, Mitchell enjoys snow skiing and mountain biking. In fact, the lawyer sets aside one week every year to enjoy Colorado's great outdoors with six to eight of his closest friends.

Mitchell is married and has two children. His wife, Mary, is a medical social worker. ■

---

**"Contractual issues  
between physicians  
and insurance  
companies are  
becoming more of  
an issue. "**

---

## Collect Bad Debt

- Cheaper
- Faster
- In compliance with the Law



If you've always used a collection agency. . . WHY?

Cut out the collection agency by retaining the Maggio Law Firm.

Save time. Save money.  
Be in compliance with the law.

Have you always used a collection agency because "that's the way you've always done it?"

*Try a new way. . . tip the scales in your favor, call Mike Maggio today.*

## MAGGIO LAW FIRM

**your collection law firm**

Offices in Conway and Searcy • 1-800-600-3201

[www.ebaddebt.com](http://www.ebaddebt.com)





# Learn From and Respond to the Medical Record

J. KELLEY AVERY, MD

**Medical malpractice cases are not lost because of errors in judgment. They are lost when the judgment errors do not follow careful use of all the data available, and the case is not handled in a logical and sound fashion based on the information the physician has.**

The patient was a 30-year-old woman who came to her obstetrician during the first trimester of her third pregnancy. With the first pregnancy the patient had a spontaneous abortion. Her second pregnancy, attended by the same obstetrician, ultimately resulted in a healthy baby, but during the prenatal period the patient was found to have gestational diabetes, and although the baby was healthy, the mother had a hard labor and a difficult delivery. There was moderate to severe shoulder dystocia and the Apgar scores were low (4 and 8). The newborn was successfully resuscitated, but this should have alerted the doctor to the possibility of a small pelvis in his patient.

Six months before her first prenatal visit she was seen for a routine check-up. The record indicated, "Normal Gyn examination. Pelvic pain and return in a year unless pain worsens." There is no further documentation of findings on this annual check-up.

On the first prenatal visit the good, complete physical examination within normal limits. The LMP was recorded as June 15, and the EDC was estimated as March 22. Her blood pressure was 126/80 mm Hg and weight 168 pounds. All the laboratory data were normal. The previous history of gestational diabetes was recorded, and the 24-hour labor with shoulder dystocia was made a part of this prenatal record. Three months later an ultrasound caused the physician to update the EDC to March 16. A fasting blood sugar was 89 mg/dl, and three hours after receiving 50 gm of glucose her blood sugar was 144 mg/dl. A week later the test was repeated, with essentially normal results. On that occasion 100 gm of glucose was given, and the three-hour blood sugar was 129 mg/dl. The patient was told that her glucose tolerance test was normal.

At about 27 weeks gestation her urine sugar was reported as 3+, and about three weeks later another GTT was done. On this occasion the fasting blood sugar was 89 mg/dl but after 100 gm of glucose, the one-hour value was 186 mg/dl,

the two-hour value 181 gm/dl, and the three-hour value 92 mg/dl.

The patient gained about 30 pounds during the pregnancy, and at about 38 weeks the obstetrician recommended that labor be induced. She was admitted to the hospital in the early morning for induction, and the routine orders were given. The fetal heart rate (FHR) was recorded in the 140 range when the Pitocin drip was begun. In the first hour of Pitocin induction the FHR was recorded in the 130s. A fairly aggressive increase in the amount of Pitocin was a part of the protocol. When the physician was contacted, he examined his patient promptly, affirming the increase in Pitocin. About three hours after induction was begun, the FHR was recorded in the range of 120-130/min.

Eight hours into the induction the head was still high and the membranes intact. An attempt was made to rupture the BOW through a cervix dilated to 1-2 cm, but it was unsuccessful. The Pitocin drip was progressively increased per protocol or direct orders, and 12 hours into the induction the FHR was recorded at 110-130/min. The cervix at this time was 4-cm dilated, but the head was not in the pelvis. The position was recorded at -2.

About 18 hours after the onset of induction, an epidural anesthetic was given, relieving the patient's pain somewhat. An hour later the first late deceleration of the FHR was noted. When the doctor was notified, the Pitocin was reduced for about 30 minutes. Within an hour, further late decelerations were noted, this time below 100/min. These findings on the electronic fetal monitor (EFM) continued and were reported to the doctor. On change of position, they would seem to improve but continued to be reported by the staff.

Twenty hours after admission to the labor and delivery suite, the obstetrician took the patient into the delivery room and attempted a forceps rotation and vacuum extraction, both of which were unsuccessful. With the

EFM continuing to show decelerations, the patient was prepared for Cesarean section (C-section), a laceration of the perineum was noted, and it was repaired before the C-section was begun.

A male infant weighing 10 pounds, 10 ounces was delivered, with Apgar scores of 1-4 and 5. He was put in the care of a neonatologist and taken to the neonatal intensive care unit. He had respiratory problems requiring ventilator support for about two weeks, and seizures in the first 12 hours. He appeared to be quadriplegic, and was discharged from the hospital with a diagnosis of hypoxic encephalopathy. He died at about 18 months of age.

The obstetrician was charged with negligence in (1) failing to determine the condition of the mother and child before inducing labor, (2) failing to obtain informed consent for the elective induction of labor, (3) electively inducing labor and (4) failure to respond appropriately to signs of fetal distress and failing to do the C-section in a timely manner. A very large settlement was required to settle this case.

### Loss Prevention Comments

Medical malpractice cases are not lost because of errors in judgment. They are lost when the judgment errors do not follow careful use of all the data available, and the case is not handled in a logical and sound fashion based on the information the physician has. The attending obstetrician had delivered a baby for the patient two years earlier. He had recorded in the hospital record that the mother was a gestational diabetic and that she had a difficult labor due to shoulder dystocia even though the baby weighed only 7 pounds, 6 ounces.

He had not documented this previous experience in the prenatal record of the patient with this pregnancy. He had acted upon that memory by doing the appropriate tests for gestational diabetes. On at least one of these glucose tolerance determinations, hyperglycemia was unmistakable, indicating gestational diabetes. She had gained about 30 pounds during the course of the pregnancy, and urine

specimens had been checked regularly for glucose. Toward the end of the prenatal period the urine was consistently glucose-positive. Ultrasound examinations had been done at expected intervals, and the condition of the baby had been determined to be normal, but nowhere in the record does the estimated weight appear.

Based on the physician's knowledge of the gestational diabetes and possibility of a macrosomic baby, the decision was apparently made to induce labor at about 38-39 weeks gestation, and the patient was admitted for this purpose at about 7 a.m.

There was no documentation of discussion with this patient about inducing labor. One presumes, giving the attending physician the benefit of the doubt, that such a discussion did take place. Perhaps the prior delivery and the difficulty she experienced with the shoulder dystocia was discussed, but we had no record of that either. The standard orders for induction were given and the protocol indicated by those orders was begun.

Examination revealed that the fetal head was not in the pelvis, and the cervix was not dilated. From the record, true labor did not start until about 2 p.m. Slow progress was made, even with regular increases in the amount of Pitocin given. It was about 5 p.m. when the patient began to require increased amounts of pain medication, and about two hours later an epidural anesthetic was given.

About 9 p.m. the nurses reported some late decelerations on the EFM. The obstetrician examined his patient and apparently was reassured by the tracing that no real problem with the fetus was developing, and the induction proceeded with increasing amounts of Pitocin. There was no physician's note on the chart or the EFM tracing to indicate his assessment or plan. Again, at about 10 p.m. the nurses reported decelerations to a FHR of "below 130," falling, but not critical. The physician examined his patient, and noted in the record that the findings were subtle and inconsistent,

but stimulation with Pitocin continued. On a thorough review, a qualified expert believed that at this point the baby was healthy.

After midnight, decelerations continued, the FHR falling to the range of 100/min and accelerations at and above 160/min. The increases in Pitocin continued according to orders. This judgment is certainly questionable in the face of the tracing and the FHR.

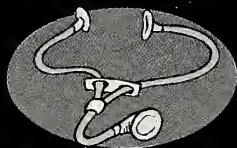
When at about 3:30 a.m. the decelerations with pushing showed rates in the 80s, lasting for 30 seconds or more, the patient was taken to the delivery room for an attempt at vacuum delivery. It failed, as did forceps rotation of the head. A laceration of the perineum was discovered, and even with the FHR at 60-80/min and with decreasing variability of the heart monitor, repair was done before the C-section was begun. Again, this was considered an error in judgment, and below an acceptable standard of care based on available data.

There were consistent deviations from an acceptable standard of care for at least three hours before delivery. This patient had had a hard labor previously with a 7 pound, 10 ounce-baby. Additionally, she had had with her previous pregnancy, and this one, gestational diabetes. The obstetrician gambled with his patient far too long in the attempt to achieve a vaginal delivery. He was attentive to his patient, came when called by the nurses, but certainly did not take into account all the facts available to him, and failed to do a timely C-section. Had he done so, this baby would have had a good chance of being born without the devastating neurologic damage that took his life at 18 months of age. ■

*Reprinted from a September 1999 issue of Tennessee Medicine. The Case of the Month is taken from actual Tennessee closed claims. An attempt is made to fictionalize the material in order to make it less easy to identify. If you recognize your own case, please be assured that it is presented solely for the purpose of emphasizing the issues presented.*



# CARDIOLOGY



## The Role of Amiodarone in the Management of Patients with Cardiac Arrest

AMY M. FRANKS, PHARM. D. CANDIDATE — KRISTA SUE WATTERSON, PHARM. D.

EDITOR: EUGENE S. SMITH, III, MD

*The standard format for this section has changed this month to consider the new American Heart Association guidelines for the treatment of ventricular tachycardia and cardiac arrest. One of the more important changes involves the recommendation of amiodarone as the primary antiarrhythmic agent. Such a change pushes amiodarone from the domain of the cardiac specialist into the standard armamentarium of the general physician. The following describes the rationale for such a move and equips the practitioner for using this agent in the appropriate settings.*

Antiarrhythmic drug therapy is commonly used in the treatment of patients in cardiac arrest due to ventricular fibrillation refractory to electrical defibrillation. The 1992 American Heart Association Advanced Cardiac Life Support (ACLS) guidelines recommended lidocaine be used as the first antiarrhythmic drug after electrical defibrillation and epinephrine administration.<sup>1</sup> However, the American Heart Association recognized that there is limited evidence from randomized controlled trials to support the routine use of lidocaine in the treatment of ventricular fibrillation. Most early studies of lidocaine use were limited by flaws in study design and the use of animal models.<sup>2,3</sup>

Since the 1992 ACLS guidelines were published, amiodarone (Cordarone®) has become available in an intravenous formulation. Amiodarone is a Vaughan Williams Class III antiarrhythmic agent with a complex mechanism of action. This agent predominantly exerts its antiarrhythmic effect by blocking potassium channels and thereby prolonging myocardial refractoriness.<sup>4,5</sup> Amiodarone's clinical effectiveness was recently evaluated in the Amiodarone for Resuscitation After Out-of-Hospital Cardiac Arrest due to Ventricular Fibrillation (ARREST) trial. This trial was a randomized placebo-controlled study that investigated the administration of amiodarone for the treatment of out-of-hospital cardiac arrest due to ventricular fibrillation (VF)/pulseless ventricular

tachycardia (VT). In this study, 504 adult patients who failed electrical defibrillation of VF/pulseless VT were randomly assigned to receive placebo or intravenous amiodarone. The study's primary endpoint was survival-to-hospital admission with a stable, organized rhythm. Compared to placebo, amiodarone therapy resulted in a statistically significant higher survival-to-admission rate (34% vs. 44%, respectively, a relative increase in survival of 29%;  $P=0.03$ ). Therefore, the addition of amiodarone to ACLS procedures resulted in the survival-to-admission of an additional one out of 10 patients treated for VF/pulseless VT. However, there was not a significant difference in survival-to-hospital discharge between the amiodarone group and the placebo group (13.4% vs. 13.2%, respectively). The authors stated the study was not designed to determine differences in the survival-to-discharge. Further studies are necessary to determine long-term survival rates after treatment with amiodarone for VF.<sup>6</sup>

Based in part on the evidence from the ARREST trial, the American Heart Association has modified its recommendations on the pharmacological treatment of cardiac arrest due to VF/pulseless VT. The Guidelines 2000 for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiovascular Care (ECC) are the first recommendations based on international consensus.

**Table. Classification of Therapeutic Interventions\***

CLASSES	INTERPRETATIONS	EXAMPLES
<b>Class I</b>	<ul style="list-style-type: none"> <li>Excellent evidence of effectiveness</li> <li>Definitely recommended</li> </ul>	Electrical defibrillation for VF/pulseless VT
<b>Class II a</b>	<ul style="list-style-type: none"> <li>Good evidence to support intervention</li> <li>Acceptable intervention</li> <li>Probably a useful intervention</li> </ul>	Sodium bicarbonate use in tricyclic antidepressant overdose
<b>Class II b</b>	<ul style="list-style-type: none"> <li>Fair evidence to support intervention</li> <li>Acceptable intervention</li> <li>Possibly a useful intervention</li> </ul>	Amiodarone for shock refractory VF/pulseless VT
<b>Class Indeterminate</b>	<ul style="list-style-type: none"> <li>Evidence is insufficient to support recommendation</li> <li>Acceptable but not recommended intervention</li> </ul>	Lidocaine for shock refractory VF/pulseless VT
<b>Class III</b>	<ul style="list-style-type: none"> <li>Beneficial evidence is absent</li> <li>Evidence suggests or confirms harm</li> <li>Unacceptable intervention</li> </ul>	Sodium bicarbonate use in patients with hypercarbic acidosis

\*Adapted from reference 7. VF = ventricular fibrillation, VT = ventricular tachycardia



These new guidelines place increased emphasis on evidence from randomized controlled trials. As in the 1992 ACLS guidelines, the initial treatment of VF places emphasis on the rapid application of CPR, electrical defibrillation and airway management.<sup>1</sup> As before, antiarrhythmic drug therapy may be utilized for VF that is

**Figure. Algorithm for Ventricular Fibrillation/Pulseless Ventricular Tachycardia\***

(assume that ventricular fibrillation / pulseless ventricular tachycardia persists after each intervention)

**Airway Breathing Circulation**  
Defibrillation up to 3 times  
(200 J, 200 to 300 J, 360 J if necessary)

↓  
**Epinephrine** 1mg IV push, repeat every 3 to 5 minutes  
(Class Indeterminate)  
— OR —  
**Vasopressin** 40 units IV as a one time single dose (Class II b)

↓  
**Resume attempts to defibrillate**  
1 x 360 J within 30 to 60 seconds

↓  
**Consider antiarrhythmic intervention:**  
**Amiodarone** 300 mg IV push as a one time single dose (Class II b). If VF/pulseless VT recurs, consider administration of a second 150 mg IV dose. Maximum cumulative dose: 2.2 g over 24 hours.  
**Lidocaine** 1 to 1.5 mg/kg IV push (Class Indeterminate). Consider repeat in 3-5 minutes to a maximum cumulative dose of 3 mg/kg. A single dose of 1.5 mg/kg in cardiac arrest is acceptable.  
**Magnesium** 1-2 g IV in polymorphic VT (torsades de pointes) and suspected hypomagnesemic state.  
**Procainamide** 30 mg/min in refractory VF (maximum total dose: 17 mg/kg) is acceptable but not recommended because prolonged administration time is unsuitable for cardiac arrest.  
**Consider buffers**

↓  
**Resume attempts to defibrillate**  
Use 360 J (or equivalent biphasic) shocks after each medication or after each minute of CPR. Acceptable patterns: CPR-drug-shock (repeat) or CPR-drug-shock-shock-shock (repeat).

\*Adapted from reference 7. VF = ventricular fibrillation, VT = ventricular tachycardia, J = Joules, IV = intravenous, CPR = Cardiopulmonary Resuscitation.

*What you pay for.*



*What you get.*



For more information about what **SKYSHARE** can mean to you call Cheri McKelvey at 375-3245 x321  
**Central Flying Service, Inc.**

## SERVING ARKANSAS' HEALTHCARE INDUSTRY

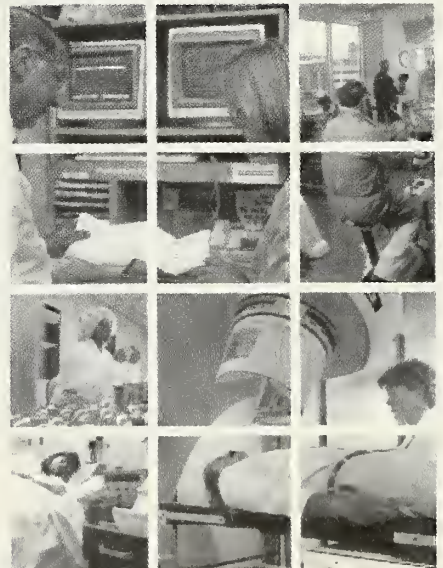
**WHEN YOUR INSURANCE NEEDS ARE UNIQUE, YOU WANT AN AGENT AND INSURANCE COMPANY THAT THINK LIKE YOU DO—INDEPENDENTLY**

Let's face it: not every insurance company will have the right insurance choices for the unique needs of the health care industry in Arkansas.

Hoffman-Henry doesn't work for any insurance company. We work for you. And our obligation is to help you find the right policy for your needs. From the right company. At the right price.

When it comes to independent thinking for the Arkansas medical community, we recommend St. Paul Fire and Marine Insurance Company. They specialize in the health care industry and will work closely with us to meet your unique insurance needs.

Call one of our three locations for a free review and consultation - before your current coverages expire.



**Hoffman-Henry**  
Insurance Corporation

Independent  
Insurance  
Agent

**TheStPaul**

*It pays to make the independent choice.*

Little Rock 501-224-8884 • Pine Bluff 870-534-4532 • Searcy 501-268-3528





Healthcare Professional Liability  
Business/Workers' Compensation/Life & Retirement  
Planning

Managing the business side of healthcare is time consuming, but FARMERS helps get you back where you belong—delivering quality medical care.

For almost 50 years, Farmers Professional Liability has specialized in providing coverage and risk management solutions to the changing liability risks associated with the delivery of healthcare.

Our Physician Program offers solutions to, and exacting coverage for, today's broad spectrum risk exposures.

We make it simple—with one call we can handle all your insurance needs!



Mark Perry  
112 Municipal Drive  
Jacksonville, AR 72076  
(501)982-4561  
1-800-467-2436  
mperry@alltel.net

Joanna Owens  
712 A Bradley Dr.  
Mtn. Home, AR 72653  
(870) 424-2120  
1-888-424-2120  
baxterinsurance@yahoo.com



refractory to electrical defibrillation. The new guidelines have modified the recommendations for the use of pharmacological agents in resuscitation. One major change in the Guidelines 2000 is the recommended use of amiodarone in place of lidocaine as first-line drug therapy of VF/pulseless VT.<sup>7</sup> (See Figure for the new VF treatment algorithm.)

In the new guidelines, the recommendations for pharmacological management are evidence-based and classified by the strength of evidence supporting its use (Table). The treatment of VF with lidocaine was given the newly defined Class Indeterminate recommendation. By definition, Class Indeterminate recommendations can still be recommended for use, but practitioners are reminded that evidence is limited to study results that may be inconsistent, contradictory or may fail to address relevant clinical outcomes. Conversely, amiodarone has been assigned a Class IIb recommendation for its use in refractory VF. Class IIb interventions are considered "within the 'standard of care.'"<sup>7</sup>

The Guidelines 2000 recommend amiodarone be administered as a single bolus infusion of 300 mg for the treatment of VF. The intravenous formulation of amiodarone is supplied as a concentrated solution in a glass ampule. The contents of the ampule should be diluted with saline or dextrose in water and rapidly injected into a peripheral vein.<sup>7</sup> Amiodarone can be safely administered undiluted (E.R. Gonzalez, oral communication, September 2000).

Other than effectiveness, amiodarone has significant advantages over other antiarrhythmic drugs, including a simple loading regimen. Amiodarone is given as a single bolus dose as opposed to the more complex administration of other antiarrhythmic agents. This bolus dose is not based on patient weight, but simply a standard 300 mg dose.<sup>7</sup> Amiodarone appears to have few significant short-term cardiovascular adverse effects.<sup>4</sup> As shown in the ARREST trial, hypotension and bradycardia that occurred with amiodarone administration were easily treated with intravenous fluids and inotropic or chronotropic support.<sup>6</sup>

From an administration standpoint, amiodarone is not currently available in a prefilled syringe due to its adherence to plastic surfaces. However, amiodarone may be administered in plastic infusion devices when infusion time does not exceed two hours.<sup>8</sup> While there is no pharmacoeconomic analysis available, the acquisition

## M E D I C A L   O F F I C E S P A C E

### DOCTORS BUILDING 500 South University Avenue Little Rock, Arkansas

Suites Available ranging from  
496 sq. ft. to 1,618 sq. ft.

Professional Management  
Maintenance 24 hours a day, 365 days a year  
Nightly janitorial service plus Day Maid  
Free Doctors Parking Lot -  
Or Low Cost Reserved Parking  
Free Use of Well Appointed Conference/Club Room  
Ancillary Services in Building

**Location convenient to all area Hospitals**  
including Baptist, St. Vincent Doctors,  
St. Vincent Infirmary, UAMS, VA  
and Arkansas Children's.

**CONTACT**  
**Betty Garcia - 664-1812**  
VISIT OUR WEBSITE [www.lrma.com](http://www.lrma.com)



cost of amiodarone is higher than previously recommended agents. Currently, the average wholesale price of a 300 mg dose of amiodarone is approximately \$168.<sup>9</sup>

In conclusion, the AHA has revised the Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care. The Guidelines 2000 have significant antiarrhythmic drug therapy changes from the previous guidelines. One major change in the new guidelines is the recommended use of amiodarone in place of lidocaine as first-line drug therapy of refractory VF. Other significant changes are included in the Guidelines 2000, and the reader is encouraged to review the new guidelines for completeness. ■

#### References

1. American Heart Association. Guidelines for Cardiopulmonary Resuscitation Emergency Cardiac Care. *JAMA*. 1992; 268:2212-2302.
2. Herlitz J, Ekstrom L, et al. Lidocaine in out-of-hospital ventricular fibrillation. Does it improve survival? *Resuscitation*. 1997; 33(3):199-205.
3. Borer JS, Harrison LA, et al. Beneficial effect of lidocaine on ventricular electrical stability and spontaneous ventricular fibrillation during experimental myocardial infarction. *Am J Cardiol*. 1976; 37:860-863.
4. Gonzalez ER, Kannewurf BS, Ornato JP. Intravenous amiodarone for ventricular arrhythmias: overview and clinical use. *Resuscitation*. 1998; 30:33-42.
5. Desai AD, Chun S, Sung RJ. The role of intravenous amiodarone in the management of cardiac arrhythmias. *Ann Internal Med*. 1997; 127 (4):294-303.
6. Kudenchuk PJ, Leonard A, et al. Amiodarone for resuscitation after out-of-hospital cardiac arrest due to ventricular fibrillation (ARREST). *N Engl J Med*. 1999; 341:871-878.
7. American Heart Association in Collaboration with the International Liaison Committee on Resuscitation. Guidelines 2000 for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care. *Circulation*. 2000; 108(2):1-157.
8. Cordarone® [package insert]. Philadelphia, Pennsylvania: Wyeth Laboratories, Inc; 1997.
9. Cardinale, V (ed.): *Drug Topics Redbook*, 104th ed. Montvale, New Jersey, Medical Economics Company, Inc., 2000.

Franks is a Pharm. D. candidate in the College of Pharmacy at the University of Arkansas for Medical Sciences in Little Rock. Watterson is with the University Hospital of Arkansas. Dr. Smith is with the division of cardiology, College of Medicine, UAMS and John McClellan Veterans Administration Hospital in Little Rock.

## ALL DRESSED UP AND READY TO GO



**Mention this ad  
and receive  
\$100 off a new  
Bombardier!**

**BOMBARDIER** Witness the new styling and impressive standard features on the all-new Traxter™ XT model from Bombardier at

**BRADFORD**  
MARINE & ATV  
ESTABLISHED 1971

8020 Landers Rd. • N. Little Rock, AR 72117 • (501) 833-2628  
8425 N. State Line • Texarkana, TX 75501 • (903) 794-2628

**BOMBARDIER**  
RECREATIONAL PRODUCTS



ENGINEERED WITH YOU IN MIND

Visit [www.bombardier-atv.com](http://www.bombardier-atv.com)

©2000 Bombardier Inc. All rights reserved.™ Trademarks and ® Registered Trademarks of Bombardier Inc. and/or affiliates in the United States of America U.S.A., the products are distributed by Bombardier Motor Corporation of America Bombardier reserves the right, at anytime, to discontinue or change specifications, prices, designs, features, models or equipment without notice and without incurring obligation. ATVs are recommended for use only by those aged 16 and older. Bombardier highly recommends that all ATV riders take a training course. For safety and training information, see your dealer or, in the U.S.A., call the ATV Safety Institute at (800) 887-2887. In Canada, call the Canadian Safety Council at (613) 739-1535 ext. 227. ATVs can be hazardous to operate. For your safety: Always wear a helmet, eye protection and other protective clothing. Always remember that riding and alcohol/drugs don't mix. Never ride on paved surfaces or public roads. Never carry passengers. Never engage in stunt driving. Avoid excessive speeds and be particularly careful on difficult terrain. Bombardier urges you to "TREAD LIGHTLY" on public and private land. Preserve your future riding opportunities by showing respect for the environment, local laws and the rights of others when you ride. Ride responsibly.

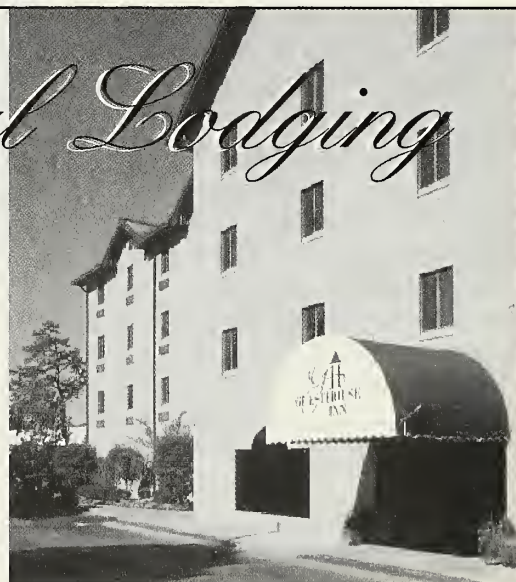
## Medical Lodging

Close proximity to all  
Little Rock hospitals

Serving Little Rock Visitors

- Medical stays
- Business travel
- Leisure travel

"Guesthouse Inn is your  
perfect home away from home  
while in Little Rock"



**GUESTHOUSE**  
Inns • Hotels • Suites

301 So. UNIVERSITY AVE. ▲ LITTLE ROCK, AR 72205 ▲ (501) 664-6800



# West Nile Fever in the United States

In the summer and fall of 1999 the first cases ever of West Nile Virus (WNV) infection occurred in the northeastern United States. The original eight cases diagnosed were clustered within a four-mile area of Queens New York. They were all healthy adults between the ages of 58 and 85 years. Symptoms included gastroenteritis, fever, altered mental status and diffuse muscle weakness. Cerebrospinal fluid (CSF) and peripheral blood parameters suggested a viral etiology.

Concurrent with the human outbreak there was an increase in bird fatalities primarily among crows. Birds are the primary host for arboviruses such as St. Louis Encephalitis and West Nile Fever. Infected birds are usually asymptomatic. The dead birds in this outbreak, however, showed pathologic evidence of viral encephalitis. Avian tissue samples were sent to the National Veterinary Service Laboratory, where a Flavivirus was isolated that was subsequently identified by the CDC as West Nile Virus.

During the outbreak, which ran from August–October, 62 humans became clinically ill with seven deaths. There were 25 equine cases with nine deaths, and at least 14 species of birds died of the infection. The dead birds were predominately crows but also included were blue jays, magpies, flamingos, herons, ducks, pheasants, eagles and others.

The question on everyone's mind was whether the disease would winter over in birds or mosquitoes and recur or spread to other states during the year 2000. That question has been answered in the affirmative.

Nationally, as of Sept. 15, 2000, avian surveillance has identified 1,471 West Nile infected birds from six states, including Connecticut, New York, New Jersey, Massachusetts, Rhode Island and New Hampshire. Ninety percent of the birds are crows that readily die with the disease. So far this year, New York has one equine case, Connecticut has three, and New Jersey has one. During the year 2000, New York has had 12 human cases and New Jersey one. These figures will change rapidly during the late summer months of August and September.

West Nile Fever is an arthropod borne human illness

characterized by an abrupt onset, fever, headaches, altered mental status, photophobia, lymphadenopathy, myalgia, rash and frequent muscle weakness. Meningoencephalitis is an occasional complication. There is often a mild leucopenia with a slight lymphocytosis. The CSF is clear with normal sugar and elevated protein levels. There is a pleocytosis with increased lymphocytes and polymorphonuclear leukocytes. Most people infected show an antibody titer but are asymptomatic. Many show a slight fever and headaches of a few day duration and recover completely. Meningoencephalitis occurs in a small percentage of people usually older than 50.

The etiological agent, West Nile Virus, is named after the district of Uganda in East Africa where it was first isolated. It is one of the earliest human arboviral infections to be documented and was initially isolated in 1937 from the blood of a febrile woman. Subsequent studies showed WNV antibodies in the human populations of East and Central Africa. The causative agent is a single strand RNA virus about 45 nm in diameter of the genus of Flaviviruses. It is closely related to other flaviviruses including St. Louis Encephalitis, Japanese B Encephalitis, Murray Valley Encephalitis and Dengue Fever. Care must be taken in the laboratory to distinguish between the viruses, which cross-react on certain diagnostic laboratory tests. The New York outbreak was originally thought to be St. Louis Encephalitis

because tests were positive for a flavivirus, and St. Louis Encephalitis was the most logical diagnosis.

There are different strains of WNV in other countries of the Eastern Hemisphere, and recently, it has been shown there are antigenic variations between strains from the same region. The strain of WNV isolated in New York was remarkable because it killed birds, and in humans it often caused muscle weakness that could be confused with Guillian Barre syndrome.

## Occurrence

The virus has been isolated from vertebrates and arthropods in 17 countries including India, Pakistan, Europe, Israel and Russia. The outbreak in New York in August 1999, was the



*Concurrent with the human outbreak there was an increase in bird fatalities primarily among crows. Birds are the primary host for arboviruses such as St. Louis encephalitis and West Nile Fever.*

first occurrence of the virus in the Western Hemisphere. It closely resembles the strain of virus found in Israel that was previously isolated from geese.

Each year from mid-August to November hundreds of millions of birds cross Israel as they migrate from Europe to the warmer African climates. Some of them carry West Nile Virus, which is picked up by mosquitoes and spread quickly to humans, causing sickness ranging from a flu-like illness to encephalitis. There are recent reports that more than 120 cases of WNV and eight deaths have occurred in Israel this year. Hundreds of more cases are suspected.

### Hosts and Reservoirs

Serological studies have shown the presence of WNV in almost all wild and domestic animals, including cattle, sheep, swine, goats, camels, rabbits, dogs, rodents, primates, bats and others. Wild and domestic birds are assumed to be the primary host responsible for infecting mosquitoes. Mosquitoes themselves are capable of ovarial transmission of the virus and therefore may carry the virus over from year to year.

In South Africa 13 species of birds experimentally infected with the virus developed a viremia of three days duration, sufficient to infect mosquitoes. In Egypt, five species of birds exposed to infected mosquitoes developed infectious viremia for three to four days. Prevalence rates between 10%–50% have been found in birds from Israel, Pakistan, Egypt and South Africa.

Humans are readily infected by mosquitoes and develop a low-level viremia that is probably insufficient to reinfect mosquitoes. In humans, viremia is most likely to occur on the first day of fever. Viremia has been demonstrated in up to 77% of infected individuals during the first day of fever. The rate dropped to 20% on the second and third days of fever.

### Prevalence and Susceptibility of Human Populations

Human seroprevalence of more than 20% has been recorded in Israel, Pakistan, Nigeria and India during

### WNV suspect patients normally present with the following symptoms:

1. Fever greater than 100° F;
2. Altered mental status (confusion, lethargy, agitation and other neurological symptoms) to include palsies, paralysis, etc.;
3. An abnormal CSF profile including negative bacterial stains, a pleocytosis with excess lymphocytes and elevated protein;
4. Muscle weakness (especially flaccid) confirmed by neurologic exam or EMG.

outbreaks of the disease. During the 1950s an estimated 40% of humans in Egypt's Nile Delta were serologically positive. The seroprevalence rate determined by random sampling in the New York City area during the 1999 outbreak was 2.6%.

### Transmission

*Culex Pipiens* and *Resturans* mosquitoes are mainly responsible for transmitting the disease in the United States. However, other species of mosquitoes have been incriminated, including *Aedes Japonica*. Bird migration appears to be the major mechanism of WNV dissemination. Widgeons migrate from Eurasia to the Northeast United States. Storms may dislocate migratory birds. Exotic birds imported to zoos may be responsible for bringing in the virus. In addition, infected mosquitoes may enter the United States in aircraft.

Since the *Culex* mosquito loves to feed on birds, they are the ideal vector.

Mites and ticks also are known to be vectors, but their significance is thought to be minor. Then there are factors in epidemics that are not understood. Bats and rodents experimentally inoculated with WNV have shown viremia. The strain of virus in the United States results in bird die-offs that are explained by the high concentration of virus in the organs and central nervous system. Certain species of birds are more susceptible, especially crows. Chickens and sparrows do not normally die of the disease but are easily infected and develop a viremia, sufficient to infect mosquitoes.

Dr. Tracy McMamara, DVM at the Bronx Zoo in New York, performed

necropsies on all dead birds and reported gross hemorrhage of the brains, splenomegaly, meningoencephalitis and myocarditis as the predominant gross pathological findings. The organs were highly viremic, enlarged, hemorrhagic or inflamed. Twenty-seven birds representing 14 species were examined. Virus was detected in 23/26 brains; 24/25 hearts 15/18 spleens, 14/20 livers, 20/20 kidneys 10/13 outbreaks, 13/14 intestine,

etc. Viral concentration was high in the tissues. This probably accounts for the high mortality rate in certain birds. St. Louis Encephalitis infection in birds does not normally cause fatalities and gross pathological changes to the extent seen with WNV infection.

### Surveillance for West Nile Virus in Arkansas

The Center for Disease Control has provided grant money to the Arkansas Department of Health to develop a program to detect WNV encephalitis in Arkansans.

Physicians are requested to report cases of aseptic meningitis and viral encephalitis to the division of epidemiology, Arkansas Department of Health, (501) 661-2597 or (501) 661-2143, so arrangements can be made for laboratory testing of serum and CSF for WNV. Specimens to submit for laboratory testing include acute sera collected during the first week of illness followed by convalescent phase sera collected two-three weeks later. Submit at least 2 ml. of each. Transport with cold packs to reach the laboratory within 24 hours if possible. CSF for virus isolation requires at least 1 ml. in a tube without preservatives. The specimen must be frozen at -70° C before shipping. ■

Please send samples to:  
Arkansas Department of Health,  
Immunology Laboratory  
4815 W. Markham St., Slot #47  
Little Rock, AR 72205

*References: Handbook of Zoonoses Second Edition, Section B Viral, CRC Press, C.D.C. Bulletin on West Nile Virus.*



# Serial Troponin I Measurements Detect Recurrent Myocardial Infarction After Initial Acute Myocardial Infarction

HANI A. RAZEK, MD — BRIAN S. ERLER, MD, PH.D. — J. DAVID TALLEY, MD

## Abstract

Serial serum troponin I and CK-MB measurements were obtained for 36 patients presenting to the emergency department with a confirmed diagnosis of acute myocardial infarction (AMI). For each patient, the normalized percentage of maximum troponin I concentration (%max Tropl) was plotted vs. the time from the maximum value to obtain a kinetic decay plot. The linear correlation plots of the  $-\text{Log}(\% \text{max Tropl})$  vs. time were compared. Patients with uncomplicated AMI ( $n = 31$ ) showed linear correlation coefficients (CC) above 0.97 (mean CC = 0.991). Patients with AMI complicated by recurrent myocardial infarction ( $n = 5$ ) documented by corroborate clinical findings, electrocardiographic abnormalities and/or abnormal CK-MB results showed linear correlation coefficients (CC) less than 0.97 (mean CC = 0.763). Using a cutoff value of CC = 0.97, both patient groups were completely separated and re-infarction or extension

of infarction was predicted with 100% accuracy, sensitivity and specificity.

Conclusion: Kinetic modeling of troponin I decay in patients with AMI correctly differentiates patients with complicated vs. non-complicated courses.

## Introduction

Cardiac Troponin I (TnI) is a protein subunit of the troponin complex that is found only in the heart and is released after myocardial necrosis.<sup>1,6</sup> Serum peak values are proportional to infarct size and are an independent predictor of short-term mortality in acute coronary syndromes even in the absence of CK-MB elevation.<sup>5</sup> Troponin I early kinetics are similar to CK-MB.<sup>2,6</sup> Since serial CK-MB measurements show multiple peaks in re-infarction or persistent elevation with extension of infarction,<sup>7,8</sup> we attempted to determine whether patients could be reliably separated into groups showing “uncomplicated” kinetics after acute myocardial in-

farction (AMI) and “complicated” kinetics that would provide early evidence of re-infarction or extension of infarction.

## Methodology

This was a retrospective, pilot study of serial serum TnI and CK-MB measurements obtained from 36 patients presenting to the emergency department with AMI. Aliquots of serum were obtained through existing indwelling peripheral catheters or at the time of other planned venipuncture every four–eight hours on day one and at intervals of eight and 24 hours on subsequent days. For quantitative determination of serum TnI, a fluorogenic enzyme-linked immunoassay (OPUS Troponin I assay) was used; this assay uses two goat polyclonal antibodies that are purified to recognize different polypeptide segments unique to the cardiac isoform of troponin I (measuring range 0.5–150 ng/ml). Values >1.5 ng/ml were considered positive for TnI in this

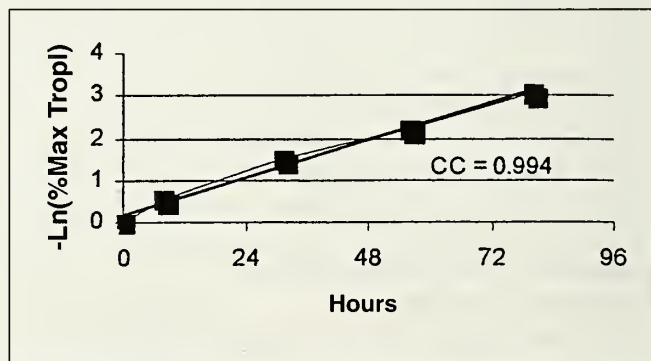
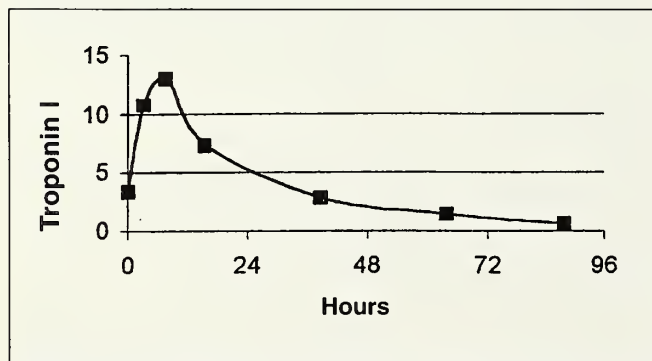


Figure 1: On plotting TnI vs. Time, note the peak, then gradual decay, that occurred in all uncomplicated MI, which followed first order exponential decay with CC > 0.97 on plotting  $-\text{Ln}(\% \text{Max Tropl})$  vs. Time.

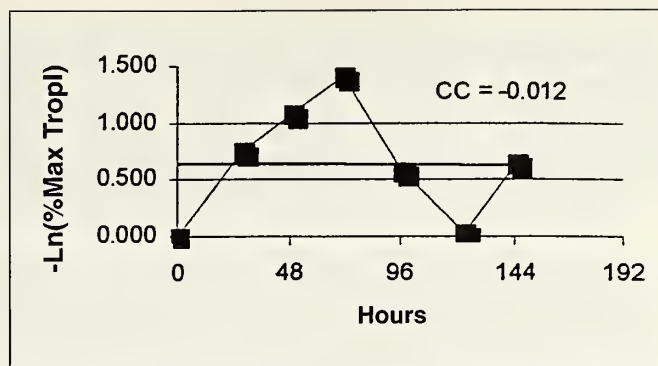
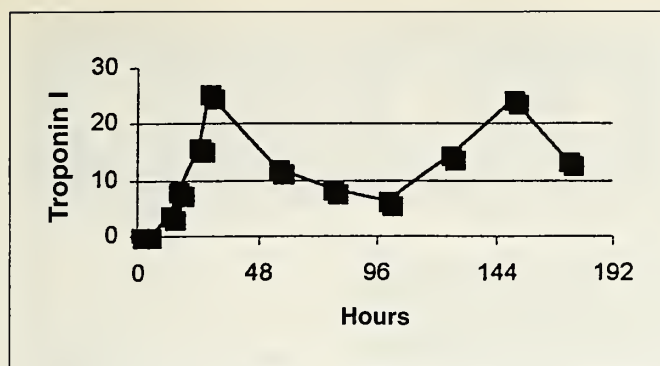


Figure 2: Plotting TnI vs. Time, note the peak, with gradual decay, until re-infarction occurred with a rise TnI, with no linear correlation and CC near 0 on plotting  $-\ln(\% \text{Max Tropl})$  vs Time.

study. The intra-assay coefficients of variation were from 4.6%–12% at values from 2.99 ng/ml–104 ng/ml. Validity of this assay has been proven in a multi-center clinical study.<sup>3</sup> For each patient, the normalized percentage of maximum troponin I concentration ( $\% \text{max Tropl}$ ) was plotted vs. the time from the maximum value to obtain a kinetic decay plot. Kinetic decay curves were analyzed without knowledge of the patient's clinical course and charts were reviewed to determine the presence or absence of complications of AMI without knowledge of serial TnI determinations.

## Results

Patients with AMI complicated by recurrent myocardial infarction or extension of infarction ( $n = 5$ ) showed troponin I decay plots with secondary peaks. These patients with complicated AMI had corroborating clinical findings, EKG abnormalities and/or abnormal CK-MB results. Patients with uncomplicated AMI ( $n = 31$ ) showed first order exponential decay kinetics of troponin I concentration with a decay constant  $K = 0.812 \pm 0.219$  (mean  $\pm$  SD). Linear correlation plots of the  $-\log(\% \text{max Tropl})$  vs. time were compared for both patient groups. The uncomplicated AMI group showed linear correlation coefficients (CC) above 0.97 (mean CC = 0.991) confirming the validity of the exponential decay kinetics model (Figure 1). Significant deviation from this kinetic model was seen for the complicated AMI group

(Figure 2) with linear correlation coefficients (CC) less than 0.97 (mean CC = 0.763). Using a cutoff value of CC = 0.97, both patient groups were completely separated and recurrent myocardial infarction or extension of infarction was predicted with 100 % accuracy, sensitivity and specificity.

## Discussion

After an AMI, approximately 20% of patients subsequently develop re-infarction or extension of their infarction during their hospitalization.<sup>7,8</sup> The significance of silent ischemia in this group has been well-documented.<sup>9</sup> This also has been documented after thrombolytic therapy and angioplasty. Of the available biochemical markers, CK-MB has been widely used to detect recurrent myocardial infarction or extension because it is labile and has an earlier clearance after an AMI.<sup>1</sup> TnI, which is an inhibitory subunit of the troponin complex, has early kinetics similar to those of CK-MB. It can be detected in the serum slightly before CK-MB (4 h after infarction), peaks after CK-MB (about 14–18 h) and persists for seven–10 days after myocardial injury.<sup>2,6</sup> There is a 13 fold greater concentration of TnI than CK-MB in the myocardium on a weight basis, thus the signal to noise ratio associated with TnI is much more favorable for detecting minor cardiac necrosis.<sup>1,5</sup> It has been documented that TnI is not detected in the serum of healthy individuals,<sup>2,5</sup> acute or chronic muscle disease, following vascular or non-cardiac surgery or

after muscle injury<sup>1,2,6</sup> and is not affected by renal failure,<sup>1</sup> whereas CK-MB is found in the serum of healthy individuals and is affected by muscle injury and renal failure. Wu et al has reported a TnI sensitivity of 100% by 6 h after AMI with an average specificity of 96%, thus making it a more cardiospecific and sensitive marker.<sup>10</sup> In our study, we tested the hypothesis that, although TnI persists for five–seven days, by continually monitoring the daily decline of serum TnI for approximately five days, any deviation from the expected decline (plateau or rise of serum TnI) would predict recurrent myocardial infarction or extension. This pilot study suggests that this hypothesis is correct and that serial TnI measurements may be useful in identifying a subset of patients with AMI who are beginning to extend their infarction or re-infarct. Further prospective analysis will help to define the validity of this hypothesis and the true clinical utility of serial TnI determination in this setting. ■

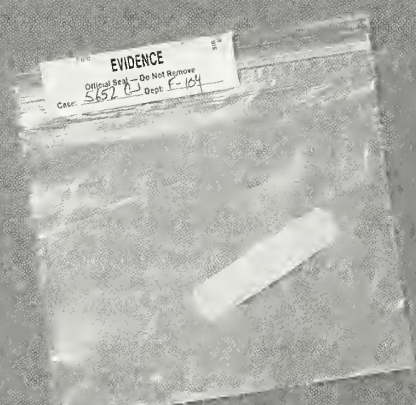
## References

1. Keffer JH. Cardiac profile and proposed practical guideline for acute ischemic heart disease. *Am J Clin Pathol* 1997;107(4):398–409.
2. Bertinchant JP, Larue C, Pernel I, Ledermann B, Fabbro-Peray P, Beck L, Calzolari C, Trinquier S, Nigond J, Pau B. Release kinetics of serum cardiac troponin I in ischemic myocardial injury. *Clinical Biochemistry* 1996;



- 29(6):587-594.
3. Larue C, Calzolari C, Bertinchant JP, Leclercq F, Grolleau R, Pau B. Cardiac-specific immunoenzymometric assay of troponin I in the early phase of acute myocardial infarction. *Clinical Chemistry* 1993;39(6):972-979.
  4. Adams JE 3d, Bodor GS, Davila-Roman VG, Delmez JA, Apple FS, Ladenson JH, Jaffe AS. Cardiac troponin I. A marker with high specificity for cardiac injury. *Circulation* 1993; 88(1):101-106.
  5. Antman EM, Tanasijevic MJ, Thompson B, Schactman M, McCabe CH, Cannon CP, Fischer GA, Fung AY, Thompson C, Wybenga D, Braunwald E. Cardiac-specific troponin levels to predict the risk of mortality in patients with acute coronary syndromes. *N Engl J Med* 1996; 335(18):1342-1349.
  6. Wong SS. Strategic utilization of cardiac markers for the diagnosis of acute myocardial infarction. *Annals of Clinical and Laboratory Science* 1996;26(4):301-312.
  7. Buda AJ, Macdonald IL, Dubbin JD, Orr SA, Strauss HD. Myocardial infarct extension: prevalence, clinical significance, and problems in diagnosis. *Am Heart J* 1983;105(5):744-749.
  8. Weisman HF, Healy B. Myocardial infarct expansion, infarct extension, and reinfarction: pathophysiologic concepts. *Prog Cardiovasc Dis* 1987;30(2):73-110.
  9. Gill JB, Cairns JA, Roberts RS, Costantini L, Sealey BJ, Fallen EF, Tomlinson CW, Gent M. Prognostic importance of myocardial ischemia detected by ambulatory monitoring early after acute myocardial infarction. *N Engl J Med* 1996;334(2):65-70.
  10. Wu AH, Feng YJ, Contois JH, Pervaiz S. Comparison of myoglobin, creatine kinase-MB and cardiac troponin I for diagnosis of acute myocardial infarction. *Ann Clin Lab Sci* 1996; 26(4):291-300.
  11. Apple FS, Henry TD, Berger CR, Landt YA. Early monitoring of serum cardiac troponin I for assessment of coronary reperfusion following thrombolytic therapy. *Am J Clin Pathol* 1996;105(1):6-10.

*Dr. Razeq is with the department of internal medicine and division of cardiology at the University of Arkansas for Medical Sciences Medical Center and the John L. McClellan Memorial Veterans Hospital, Little Rock. Dr. Erler is with the department of pathology at Jersey Shore Medical Center, Neptune, N.J. Dr. Talley is a cardiologist in Paducah, KY.*



**Exhibit A:**

Adhesive bandage, which plaintiff alleges defendant pulled rapidly from skin, violently tearing three hairs from plaintiff's arm, which resulted in severe shock, trauma, disfigurement, chronic debilitating pain and permanent psychological damage.

To protect your reputation, we take every claim seriously.

Even the most absurd claims can be damaging if they're not handled properly. Which is why the full weight of our more than 60 years of experience in medical liability insurance is brought to bear on each and every claim, no matter how frivolous that claim may appear. In fact, when appropriate, we have appealed cases all the way to the United States Supreme Court, at no additional cost to policyholders. Because you can't put a bandage on a damaged reputation.

**The St Paul**

©2000 St. Paul Fire and Marine Insurance Company  
Coverages underwritten by St. Paul Fire and Marine Insurance Company or another member of The St. Paul Companies  
[www.stpaul.com](http://www.stpaul.com)



# PEOPLE+EVENTS

## HONORED

### Dr. Logan Named Association President

Dr. Charles W. Logan has been elected president of the South Central Section of the American Urological Association.

The South Central Section is a regional urological association, including Arkansas, Missouri, Kansas, Nebraska, Oklahoma, New Mexico, Colorado, Texas, Central America and Mexico. The South Central Section holds an annual meeting with five days of scientific programs, showcasing various academic programs.



Dr. Logan

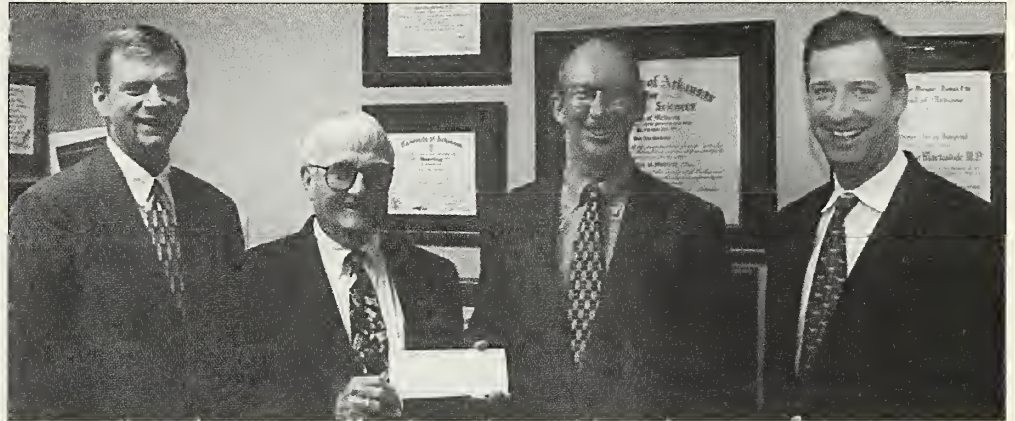
### Springdale Physician Named Cancer Liaison

Dr. Andre B. Whiteley of Springdale recently received a three-year appointment as cancer liaison physician for the Hospital Cancer Program at Washington Regional Medical Center in Springdale.

Dr. Whiteley is among a national network of more than 1,800 volunteer cancer liaison physicians who provide leadership and support to Commission on Cancer programs, sponsored by the American College of Surgeons.

### Monticello Physician Honored by Residents

Dr. Ralph Maxwell of Monticello received the Outstanding Extramural Faculty Teaching Award from residents



Joseph Martindale (second from left), director of the Arkansas Medical Foundation, receives a \$20,000 check from (left to right) Thad DeHart, SVMI's marketing representative, Steven Williams, chief executive officer of SVMI, and Randy Meador, SVMI's vice president of marketing

### Special Thanks to State Volunteer Mutual Insurance Co.

We would like to present a special thank you to State Volunteer Mutual Insurance Co. (SVMI) for its continued support of the Arkansas Medical Foundation (Physician's Health Committee). Recently, SVMI presented the foundation with a check for \$20,000. SVMI feels this contribution is an investment. Tennessee's program has been successful in reducing malpractice claims.

State Volunteer Mutual Insurance Co., organized by the Tennessee Medical Association, has been very supportive of other activities of the Arkansas Medical Society.

at the University of Arkansas for Medical Sciences.

Each year, a number of residents come to Monticello's Drew Memorial to observe local doctors.

### Camden Physician, Doctor of the Year

Dr. Lawrence F. Braden, a family physician at Ouachita Valley Family Practice Clinic in Camden, has been named the 2000-2001 Arkansas Family Doctor of the Year by the Arkansas Academy of Family Physicians.

Dr. Braden, who was born in Hawaii, is a U.S. Navy Vietnam veteran. He completed his medical degree at UAMS and is a diplomat of the American Board of Family Practice. For many years he has served as a preceptor for family practice residents, interested

high school students and medical students. This past year, he spent one day a week promoting rural health practice to medical students.

Dr. Braden is active in the community, helping found the Christian Health Center, a community clinic providing care to the working poor. He was recently named as health officer for Ouachita County.

Dr. Braden, who has been married for 31 years to wife Dyan, has three children.

### UAMS Physician Named Surgery Association President

Dr. Nicholas P. Lang, professor of surgery and associate director of the residency program at UAMS in Little Rock, has been named president of the Southwestern Surgical Congress.

Dr. Lang, chief of surgical service at the Central Arkansas Veterans Healthcare System, is a native Arkansan, who graduated from UAMS in 1973. The Southwestern Surgical Congress has members in 16 states and promotes the progress of surgery.

### AMA Names PRA Recipients

Each month the American Medical Association presents the Physician's Recognition Award to those who have completed acceptable programs of continuing education.

AMA recipients for April include Drs. Roy D. Coleman of White Hall; Kenneth P. Collins of Harrison; Jonathan M. Cook and Lynda B. Milligan of North Little Rock; Rebecca R. Floyd of Van Buren; Edward J. Jones of Batesville;



Robert L. Kerr and Kenneth M. Kilgore of Mountain Home; Glen C. Knowles of Bradford; Albert S. Koenig of Fort Smith; James Z. Mason and David R. Rozas of Little Rock; Elvin L. Norris of Beebe; and Robert L. Prosser of McGehee.

### **Jonesboro Physician Honored by Clinic**

Dr. Doug Maglothin, a Jonesboro family practice physician, was recently recognized by the board of directors of the Jonesboro Church Health Center for his eight-year tenure as medical director of the facility.

Dr. Maglothin will be succeeded by Dr. William Hurst.

During Dr. Maglothin's tenure, about 9,000 patients were served at the clinic, which provides health care and counseling services to persons with no insurance.

### **Pine Bluff Resident Presented Award**

Dr. Kristy Clinton Cowherd, a third-year family medicine resident at AHEC-Pine Bluff, has been selected as one of 20 recipients of the Mead Johnson Awards for Graduate Education in Family Practice.

Mead Johnson paid for Dr. Cowherd to attend a September award banquet in Dallas. She is a 1998 UAMS College of Medicine graduate.

## **OBITUARIES**

### **Dr. Karen L. Colwell**

Dr. Karen Louise Colwell, 44, an internist in Little Rock died Sept. 12.

Dr. Colwell was born in Benton and attended the

University of Arkansas at Fayetteville and UAMS. Friends and family say Dr. Colwell was devoted to her sons and was active in their activities, such as scouting.

She is survived by her sons, James Henry and Mark Henry of Little Rock; her parents, Lee and Barbara Colwell of Little Rock; brother Paul Lee Colwell of Dallas; and numerous other relatives.

### **Dr. Rex C. Ramsay Jr.**

Dr. Rex C. Ramsay Jr., 72, of Hot Springs died Aug. 28.

Dr. Ramsay, born in Nashville, Ark., was the former director of the state Department of Health from 1974-1979. He also was past medical

director for the Alcoa plant in Bauxite and a retired captain of the U.S. Naval Reserves.

Dr. Ramsay was awarded the 1999 Distinguished Service Award Lifetime Achievement Award by the American Lung Association.

He is survived by his wife of 46 years, Tee Ramsay of Hot Springs; two sons and a daughter-in-law, Pat and Brenda Ramsay and Larry Ramsay, all of Dallas; four daughters and son-in-laws, Cheryl and Tollie Green of Hot Springs, Wendy and Jim Liszewski of Dallas, Becca and Lee Winningham of Center Ridge and Christy and Mace Robinson of Pearcy; two sisters; 11 grandchildren; and two great-grandchildren. ■

**Correction** In the October 2000 issue, Dr. Lonnie Harrison was incorrectly identified. Dr. Harrison is proctoring the Arkansas Heart Hospital in Little Rock and is proctoring the chief of cardiology at the Oshner Clinic in New Orleans, University of Alabama and several other cardiac programs in the country.



## ***ARE YOU LOOKING TO SLOW DOWN?***

### **Arkansas is the place for you!**

#### **Staff Physicians and Medical Directors Needed.**

Primary & Supplemental Opportunities available in Heber Springs, Jonesboro, Searcy Walnut Ridge, Wynne. Annual Volumes Range 6,500 to 35,000.

Must be BC/BP EM or PC, Residents welcomed in some locations, ACLS/ATLS/PALS.

PhyAmerica offers competitive remuneration, IC status and procured malpractice.

For more information on this and other opportunities in Arkansas, please contact

**Traci Mahlmeister, Physician Recruiter** at PhyAmerica Physician Services,

**800-476-5986**, fax CV to 919-382-3274, or e-mail [tmahlei@phyamerica.com](mailto:tmahlei@phyamerica.com).





# 2000 Membership Roster

Arkansas Medical Society  
Celebrating 125 Years



## American Medical Association Principles of Medical Ethics

- I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.
- II. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.
- III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.
- IV. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.
- V. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
- VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.
- VII. A physician shall recognize a responsibility to participate in activities contributing to an improved community.





# Arkansas Medical Society

## 2000 Membership Roster

As of Oct. 2, 2000 — Please note: If you can't find a particular physician in the county listings, look under the Direct Member Section beginning on page 220. Direct Member indicates AMS members who are not members of their county medical society or whose county membership was pending at the time of this Journal's printing. # Denotes deceased member.

### Arkansas County

Barwick, Loring Jr.  
Burleson, Stan W.  
Daniel, Noble B. III  
Elam, Garrett  
Ferrari, Victor J. Jr.  
Hestir, John M.  
Hord, Marion E.  
Millar, Paul H. Jr.  
Northcutt, Carl E.  
Pritchard, Jack L.  
Speer, Hoy B. Jr.  
Speer, Marolyn N.  
Wood, Gary P.  
Yelvington, Dennis B.

### Ashley County

Burt, Frederick N.  
Garcia, Luis F.  
Gresham, Edward A.  
Heder, Guy W.  
Henry, William Jr.  
Kula, Zbigniew  
Malloy, Mark  
Rankin, James D.  
Salb, Robert L.  
Thompson, Barry V.  
Toon, D. L. #  
Wagoner, Charles H.  
Walsh, Benjamin J.  
Wilson, Alan K.

### Baxter County

Adkins, Kevin J.  
Baker, Robert L.  
Barker, Monty  
Barnes, Gregory  
Bruton, Ronald Ford  
Burgess, Richard C.  
Chatman, Ira D.  
Cheney, Maxwell G.  
Chock, Daniel P.  
Clarke, James S.  
Cogburn, Bob E.  
Condrey, Yoland M.  
DeYoung, Bruce  
Dyer, William  
Dykstra, Peter C.  
Elders, John Gregory

Foster, Robert D.  
Gocio, John C.  
Hagaman, Michael S.  
Hardin, Philip R.  
Hodges, Michael E.  
Johnson, Stacey M.  
Kelley, Lawrence A.  
Kerr, Robert L.  
Kilgore, Kenneth M.  
Knox, Thomas E.  
Landrum, William  
Lawrence, George S.  
MacKercher, Peter A.  
Massey, James Y.  
May, Brett H.  
McAlister, Matthew  
McBride, Anthony D.  
McKelvey, Kent D. Jr.  
Millstein, David I.  
Neis, Paul R.  
Price, Michael D.  
Regnier, George G.  
Robbins, Bruce  
Roberts, David H.  
Saltzman, Ben N.  
Sneed, John W. Jr.  
Stahl, Ray E. Jr.  
Sward, David T.  
TerKeurst, John  
Tullis, Joe M.  
Turner, Frederick C.  
Wells, Gary  
White, Edward  
White, Richard B.  
Wilson, Jack C.  
Wren, Mary

### Benton County

Addington, Alfred R.  
Alderson, Roger  
Allen, L. Barry  
Arkins, James  
Baker, James  
Ball, Eugene H.  
Becton, Paul Jr.  
Benjamin, George  
Berry, Michael F.  
Black, Randall Wayne  
Bledsoe, James H.

Boden, Donna  
Boozman, Fay W. III  
Cantwell, Janet  
Clemens, R. Dale  
Cole, Randall E.  
Cooper, Scott  
Costaldi, Mario E.  
Cuchia, John  
Dang, Minh-Tam  
David, Wendy S.  
Deatherage, Joseph R.  
Diacon, W. Lindley  
Dickinson, Rodger C. Jr.  
Donnell, Robert W.  
Elkins, James P.  
Emerson, Kimberly  
Ewart, David  
Fangmeier, Angela Anne  
Fioravanti, Bernard L.  
Friesen, Douglas L.  
Garrett, David C. III  
Goss, Stephen  
Haney, R. Kevin  
Hill, Joy  
Hitt, Jerry L.  
Hof, C. William  
Holder, Robert E.  
Horner, Glennon A.  
Hull, Robert R.  
Huskins, James D.  
Johnson, Donna  
Johnson, Royce Oliver II  
Johnson, Steven P.  
Jones, Nancy  
Keane, Patrick K.  
Lanier, Karen A.  
Lewis, Rebecca C.  
Low, Lisa  
Lueders, Andrew J.  
Marciniak, Douglas L.  
McAlister, Robin  
McCollum, William  
McKnight, William D.  
Meehan, Ralph E. Jr.  
Mertz, John Douglas  
Mullins, Neil D.  
Nugent, Loyd  
Pappas, John J.  
Pearson, Richard N.

Pickens, James L.  
Platt, Michael R.  
Poemoceah, Kenneth M.  
Puckett, Billy J.  
Reese, Michael C.  
Revard, Ronald  
Ritz, Ralph C.  
Rollow, John A.  
Rolniak, Wallace A.  
Schaefer, George  
Springer, Dan J.  
Steadman, Hunter M. Jr.  
Stinnett, Charles H.  
Stinnett, Scott G.  
Stolzy, Sandra  
Swaim, Terry J.  
Swindell, William G.  
Tate, Jeffrey  
Thompson, Alice A.  
Travis, Patrick  
Treptow, Douglas  
Turley, Jan T.  
Ubben, Kenneth  
Vanderpool, R. Douglas  
Vest, Carl E.  
Warren, Grier D.  
Weaver, Robert H.  
Webb, William  
Whiteside, Edwin  
Wilson, Cynthia  
Wright, Larry D.  
Youngblood, Thomas

### Boone County

Abdelaal, Ali F.  
Ashe, Barbara  
Bell, Thomas Edward  
Bennett, Joe D.  
Brandon, Henry  
Causey, Robert Marcus  
Chambers, Carlton L. III  
Chambers, Sue  
Clary, Cathy  
Collins, Kenneth  
Daniel, Charles D.  
Dunaway, Geoffrey  
Ferguson, Noel F.  
Flanigan, Stevenson  
Ghosh, Asish Kumar

Hawk, James M.  
 Helmling, Robert L.  
 Kim, Hyewon  
 Klepper, Charles R.  
 Langston, James David  
 Langston, Robert H.  
 Langston, Thomas A.  
 Ledbetter, Charles A.  
 Leslie, Sharron J.  
 Maes, Stephen R.  
 Mahoney, Paul L. Jr.  
 Maris, Mahlon O.  
 McNutt, Joseph  
 Mears, Bill  
 Miller, Robert Jr.  
 Padilla, Jose S. Jr.  
 Reese, Ronald R.  
 Scroggins, Sam J.  
 Steinsiek, J. Bill II  
 Van Ore, Stevan Michael  
 Vowell, Don R.  
 Waters, James Dana  
 Williams, Rhys A.

### **Bradley County**

Chambers, F. David  
 Engelkes, LaDonna D.  
 Foscue, David  
 Marsh, James W.  
 Pennington, Kerry F.  
 Purvis, Kenneth W.  
 Wharton, Joe H.  
 Wynne, George F.

### **Carroll County**

Albrecht, Tammy G.  
 Card, Shannon R.  
 Corrie, Doug  
 Flake, William K.  
 Horton, Charles  
 Kresse, Gregory  
 Malone, Mark S.  
 Martinson, Alice  
 Nash, John R.  
 Ricciardi, Joseph M.  
 Rose, Steve  
 Sloan, Fredric J. II #  
 Spurgin, Randal T.  
 Stensby, Harold F.  
 Taylor, Richard L.  
 Wallace, Oliver  
 Warner, Milo N.

### **Chicot County**

Burge, John P.  
 De Ramos, Agapito Y.  
 Folk, Benjamin Perry  
 Ganta, Sanyasi Rao  
 Hicks, Charles E.  
 Kronfol, Ned  
 Martin, Andrew Ayers  
 Russell, John R.

Smith, Major E.  
 Thomas, H. W.  
 Tuangsithtanon, T.  
 Weaver, William J.  
 Wilson, Thomas C.

### **Clark County**

Anderson, P. R.  
 Balay, John W.  
 Dorman, Robert A.  
 Elkins, John S.  
 Ford, Michael Ray  
 Fullerton, John C. III  
 Hagood, Noland Jr.  
 Jansen, Mark  
 Lowry, James L.  
 McLeod, Kevin  
 Peeples, George R.  
 Taylor, George D.  
 Teed, Frank S.

### **Cleburne County**

Ashabranner, Wesley J.  
 Baldridge, Max  
 Barnett, Michael  
 Bivins, Franklin Jr.  
 Lambert, James C.  
 McNair, James R.  
 Quinn, Cynthia D.  
 Sharp, Jan  
 Stone, Timothy  
 Thomas, Jerry L.  
 Tvedten, Tom  
 Vaughan, G. Lee

### **Columbia County**

Alexander, John E. Sr.  
 Alexander, John E. Jr.  
 Dickson, D. Bud  
 Edwards, Frank Damon  
 Evans, Matthew L.  
 Farmer, John M.  
 Griffin, Rodney L.  
 Hester, Joe D.  
 Kelley, Charles W.  
 McMahan, H. Scott  
 Murphy, Fred Y.  
 Parkman, Robert L. Jr.  
 Pullig, Thomas A.  
 Roberts, Franklin D.  
 Walker, Jack T.  
 Wynn, Chester

### **Conway County**

Hickey, Thomas H. #  
 Lipsmeyer, Keith M.  
 Owens, Gastor B. #  
 Wells, Charles F.

### **Craighead-Poinsett County**

Allen, John M.

Alston, Herman D.  
 Ameika, James A.  
 Aston, J. Kenneth  
 Awar, Ziad  
 Ball, John  
 Barker, Charles  
 Basinger, James W.  
 Beck, M. Lowery  
 Behrens, Bing X.  
 Berry, Donald M.  
 Berry, Michael P.  
 Blachly, Ronald J.  
 Blaylock, Jerry D.  
 Braden, Terence P. III  
 Brown, Mark C.  
 Burns, Richard G.  
 Burns, Robert  
 Carpenter, Kennan  
 Clopton, Owen H. Jr.  
 Cohen, Robert S.  
 Cook, John  
 Cranfill, Ben  
 Cranfill, General L. III  
 Crawley, Michael E.  
 Day, Thomas Elkins  
 Degges, Russell D.  
 Delacey, Norbert Jr.  
 Diamond, Kevin  
 Dickson, Glenn E.  
 Dow, J. Timothy  
 Dudley, Millicent  
 Duke, Billy L. II  
 Dunn, Charles C.  
 Eddington, William R.  
 Edwards, Carl B.  
 Emerson, Steven  
 Eubanks, K. Dewayne  
 Felts, Larry S.  
 Fields, L. Brad  
 Foote, John W.  
 Forestiere, A. J.  
 Ganong, Kevin Donald  
 Garner, B. Matt  
 Garner, William L.  
 George, F. Joseph  
 Golden, Stephen C.  
 Good, Daniel J.  
 Gossett, Clarence E.  
 Green, Terri  
 Green, William Robert  
 Guinn, Donald R.  
 Hackbarth, Mark A.  
 Hall, Ray H. Jr.  
 Harvey, Bryan  
 Hatley, Russell  
 Hiers, Connie L.  
 Hightower, Michael D.  
 Hill, Roger D.  
 Hogue, Ernest L.  
 Hong, Michael Tzuoh  
 Hornbeck, Robert G.  
 Houchin, Vonda

Hurst, William  
 Isaacson, Michael L.  
 Jennings, R. Duke  
 Jiu, John B.  
 Johnson, John A.  
 Johnson, Larry H.  
 Johnson, Roehl W.  
 Jones, K. Bruce  
 Jones, R. J.  
 Kalife, Gerardo  
 Keisker, Henry W.  
 Kemp, Charles E.  
 Kroe, Donald J.  
 Laffoon, Scott L.  
 Lamb, Trent R.  
 Landry, Robert J.  
 Lansford, Bryan  
 Lawrence, Robert O. Jr.  
 Ledbetter, Joseph W.  
 Lepore, Diane G.  
 Levinson, Mark  
 Lewis, David M.  
 Locke, Stephen Wayne  
 Lunde, Stephen P.  
 Luter, Dennis W.  
 Lynch, John  
 Mackey, Michael  
 Maglothin, Douglas L.  
 Mahon, Larry E.  
 Marzewski, David  
 Matthews, David  
 McClurkan, Michael  
 McDaniel, Craig A.  
 McGrath, A. Joseph Jr.  
 McKee, Sanders  
 Monte, Marc  
 Montgomery, Earl W.  
 Moseley, Claiborne II  
 Owens, Ben Jr.  
 Parten, Dennis  
 Patel, Suresh  
 Phillips, John K.  
 Price, Edwin F.  
 Price, Herbert H. III  
 Ragland, Darrell G.  
 Rainwater, W. T.  
 Rauls, Stephen R.  
 Reinhard, Richard Mast III  
 Ricca, Dallie  
 Ricca, Gregory F.  
 Richards, Fraser M.  
 Rogers, James F.  
 Rusher, Albert H. Jr.  
 Sales, Joseph Hugh  
 Sanders, James W.  
 Sapiro, Gary S.  
 Savage, Patrick Joseph  
 Schrantz, James L.  
 Scriber, Ladd J.  
 Scroggin, Carroll D. Jr.  
 Shanlever, William T.  
 Sifford, Mark



Skaug, Phyllis  
 Skaug, Warren A.  
 Smith, Floyd A. Jr.  
 Smith, Vestal B.  
 Sneed, Jane  
 Snodgrass, Scot J.  
 Sparks, Barrett  
 St Clair, John T. Jr.  
 Stainton, Robert M. Jr.  
 Stallings, Joe H. Jr.  
 Stank, Thomas M.  
 Stevenson, Richard  
 Stidman, Jeff  
 Stripling, Mark C.  
 Stroope, Henry F.  
 Stubblefield, Sandra  
 Stubblefield, William  
 Swingle, Charles G.  
 Tagupa, Eumar  
 Taylor, Robert D.  
 Tedder, Barry C.  
 Tedder, Michael E.  
 Templeton, Gary L.  
 Tidwell, Kenneth Jr.  
 Tonymon, Kenneth  
 Tuck, Rebecca  
 VanScoy, Sara Elsie  
 VanScoy, William R.  
 Vines, Troy Alan  
 Vollman, Don B. Jr.  
 Walker, Meredith M.  
 White, Anthony T.  
 Wiggins, H. Lynn  
 Wilson, Joe T. Jr.  
 Woloszyn, John  
 Woodward, Gary W.  
 Young, William C. Jr.

### Crawford County

Archer, Ernest W.  
 Darden, Lester R.  
 Darrow, Bruce A.  
 Delk, John II  
 Dillard, Carolyn  
 Edds, Millard C. #  
 Edwards, Henry N.  
 Floyd, Rebecca R.  
 Garrett, Kipton L.  
 Hamby, Jeffrey  
 Harford, Scott  
 Heaver, Holly M.  
 Hefner, David P.  
 Jennings, Charles A.  
 Katz, Catherine  
 Mason, Joe N.  
 Ross, R. Wendell  
 Sasser, L. Gordon III  
 Schlabach, Ronald D.  
 Stanton, William B.  
 Travis, A. Lawrence  
 Whatcott, Brett

### Crittenden County

Adler, Justin Jr.  
 Arnold, Sidney W.  
 Barr, Marian  
 Bryant, G. Edward Jr.  
 Clemons, Mark  
 DeRossitt, James P. III  
 Deneke, Milton D.  
 Evans, Loraine J.  
 Ferguson, Scott  
 Ferguson, T. Murray #  
 Ford, David W.  
 Ford, Robert C. Jr.  
 Goodman, David Aaron  
 Hernandez, Jacinto  
 Huffstutter, Paul J.  
 Kaplan, Bertram  
 L'Heureux, Guy J.  
 Lum, Diane  
 Miller, James L.  
 Mirza, Mashhud Munir  
 Murray, Ian F.  
 Nadeau, Kenneth R.  
 Peeples, Chester W. Jr.  
 Peeples, Guy Langley  
 Pierce, Trent P.  
 Rudorfer, Bennett Lewis  
 Ruiz, Julio P.  
 Salgueiro, Carlos A.  
 Schoettle, Steve P.  
 Shrader, Floyd R.  
 Smith, Bedford W.  
 Utley, L. Thomas  
 Valdes, Raymond P.  
 Wah, John  
 Ward-Jones, Susan  
 Webb, Dan W.  
 Westmoreland, Daniel  
 Wright, William J.

### Cross County

Beaton, J. Trent  
 Beaton, Kenneth E.  
 Burks, Willard G.  
 Crain, Vance J.  
 Hayes, Robert A. Jr.  
 Jacobs, James R.  
 Rindt, Phillip Lee

### Dallas County

Delamore, John H.  
 Howard, Don G.  
 Nutt, Hugh A.  
 Wilkin, Timothee

### Desha County

Asemota, Steve  
 Go, Peter Kong Hua  
 Harris, Howard R.  
 Masquil, Filipe  
 Mehta, Hemal  
 Prosser, Robert L. III

Scott, Robert B.  
 Stewart, R. Todd  
 Turney, Lonnie R.  
 Young, James E.

### Drew County

Busby, Arlee K.  
 Connelley, Jay  
 Huey, Sandra S.  
 Maxwell, Ralph M.  
 Reinhart, Jeffrey  
 Ridout, Robert G. III.  
 Wallick, Paul A.  
 Williams, William III  
 Wilson, Harold F.

### Faulkner County

Angel, Carol  
 Beasley, Margaret D.  
 Beasley, Thomas O.  
 Bell, F. Keith  
 Bowlin, Randal  
 Bowman, Gary  
 Carter, D. Mike  
 Cheek, Ben H. #  
 Cole, Andrew  
 Collins, Mitchell L.  
 Connaughton, Michael A.  
 Cummins, J. Craig  
 Daniel, Sam V.  
 Dobbs, John C.  
 Dodge, Ben  
 France, Diane P.  
 Furlow, William C.  
 Garrison, James S. #  
 Ghormley, J. Tod  
 Gordy, L. Fred Jr.  
 Gullic, Phillip T.  
 Hendrickson, Richard O. Jr.  
 Hudson, Thomas F. III  
 Jackson, Carole  
 Kendrick, Gregory  
 Landberg, Karl H.  
 Landgren, Robert C.  
 Lewis, Gregory  
 Magie, Jimmie J.  
 Martin, David A.  
 McChristian, Paul L.  
 Murphy, Kenneth  
 Naylor, David L. Jr.  
 Norris, Lloyd P.  
 Ohrn, Maria A.K.  
 Raney, Herschel D. Jr.  
 Roberts, Thomas  
 Shaw, Collie B.  
 Shirley, David C.  
 Smith, John D.  
 Smith, Lander A.  
 St. Amour, Scott C.  
 Stancil, Vicki  
 Stone, Phillip  
 Throneberry, Bart

Trussell, Anne  
 Tsuda, Sue

### Franklin County

Carrick, Garreth  
 Gibbons, David L.  
 Lachowsky, John  
 Long, C. C.  
 Smith, John C.  
 Westbrook, Michael R.  
 Wilson, Robert

### Garland County

Abraham, Jacob E.  
 Agee, Kimberly R.  
 Arthur, James M.  
 Aspell, Robert  
 Bandy, Preston R.  
 Barnes, Jerome D.  
 Bearden, Jeffrey C.  
 Bennett, Keith  
 Bodemann, Diane  
 Bodemann, Donald R.  
 Bodemann, Michael C.  
 Bodemann, Stephen L.  
 Bohnen, Loren O.  
 Boos, Donald Jr.  
 Borg, Robert V.  
 Borland, Judy  
 Braley, Richard E.  
 Brandt, John O.  
 Braun, James R.  
 Brunner, John H.  
 Bumpas, Timothy F.  
 Burton, Frank M. #  
 Burton, James F.  
 Campbell, James W.  
 Capel, Denise Louise  
 Cates, Jack A.  
 Cenac, Joseph W. Jr.  
 Clardy, William F.  
 Cupp, Cecil W. III  
 Davis, Katrina  
 Davis, Sheryl L.  
 Dodd, Lawrence  
 Dodson, John W. Jr.  
 Dolan, Patrick III  
 Drake, Gary M.  
 Dunn, Richard W.  
 Dykman, Kathryn  
 Eisele, W. Martin  
 English, P. Timothy  
 Erwin, John  
 Finch, Richard R.  
 Fine, B.D. Jr.  
 Fore, Robert W.  
 Fotioo, George J.  
 Frais, Michael A.  
 French, James H.  
 Gammill, Todd  
 Gardner, James L.  
 Garrett, W. Michael

Gerber, Allen D.  
 Griffin, James E.  
 Grose, Andrew  
 Haggard, John L.  
 Hale, Kevin D.  
 Hardy, Ross A.  
 Harper, Edwin L.  
 Harrison, Jack W.  
 Headrick, Daniel  
 Hechanova, D. M. Jr.  
 Heinemann, Fred M.  
 Heinemann, Phyllis E.  
 Henderson, Francis M.  
 Herrold, Jeffrey W.  
 Hickman, Michael P.  
 Hill, H. Randy  
 Hill, Robert L.  
 Hitt, W. C. Jr.  
 Hollis, Thomas H.  
 Horner, Charles R. Jr.  
 Howe, H. Joe  
 Hughes, James A.  
 Hulsey, Matthew  
 Humphreys, Robert P.  
 Hunter, Karla  
 Irwin, William G.  
 Jackson, Brian D.  
 Jackson, Haynes G.  
 Jackson, Haynes G. Jr.  
 Jayaraman, Vilasini D.  
 Johnson, Paulette S.  
 Johnson, Robert D.  
 Johnston, Gaither C.  
 Josef, Stanley  
 Kaler, Ron A.  
 Keadle, William R.  
 Kincheloe, A. Dale  
 Kleinhenz, Robert W.  
 Klugh, Walter G. Jr.  
 Koehn, Martin A.  
 Larey, Mark E.  
 LeMay, Thomas B.  
 Lee, Allen R.  
 Lee, William R.  
 Longo, Margaret F.  
 Lucas, Shauna L.  
 Martin, Jana  
 Maruthur, Gopakumar  
 Mashburn, William R.  
 Mathews, John S.  
 McClard, Helen  
 McCrary, Robert F. Jr.  
 McFarland, Mike S.  
 McMahan, James  
 Meek, Gary N.  
 Munos, Louis R.  
 Olive, Robert Jr.  
 Pace, John Robert  
 Pai, Balakrishna  
 Pappas, Deno P.  
 Parkerson, Cecil W.  
 Peeples, Raymond E.

Pellegrino, Richard  
 Pilkington, Cheryl E.  
 Plaza, Jesus' A.  
 Powell, Brenda  
 Queen, George P.  
 Rainwater, W. Sloan  
 Raney, Jerel L.  
 Reddy, Prabhakara K.  
 Robbins, Mark  
 Robert, Jon M.  
 Rogers, Marc  
 Roper, Richard  
 Rosenzweig, Joseph L.  
 Russell, Mark  
 Sanders, Hallman E.  
 Seifert, Kenneth A.  
 Sharma, Bimlendra  
 Shelby, Eugene M.  
 Shroff, Rajesh K.  
 Simpson, John B.  
 Slagle, Gregory S.  
 Slaton, G. Don  
 Sloand, Timothy Peter  
 Smith, Bruce L. Jr.  
 Smith, John W.  
 Smith, Phillip L.  
 Sorrels, John W.  
 Spiers, Jon P.  
 Springer, Melvin R. Jr.  
 Springer, William Y.  
 St. John, Greg  
 St. John, Melody  
 Stecker, Elton H. Jr.  
 Stecker, Rheeta M.  
 Stough, D. Bluford III  
 Tangunan, Priscilla L.  
 Tapley, David R.  
 Thomas, W. Al  
 Tucker, R. Paul  
 Vallery, Samuel W.  
 Vogel, Eric D.  
 Wagenhauser, Karl F.  
 Wallace, Thomas "Tom"  
 Walley, Luther R.  
 Warren, E. Taliaferro  
 Watermann, Eugene  
 Waters, Samuel  
 Webb, Timothy  
 Woodward, Philip A.  
 Wright, Charles C.  
 Yang, Leo  
 Young, Michael J.

#### **Grant County**

Heise, Brian A.  
 Irvin, Jack M.  
 Paulk, Clyde D.  
 Winston, Scott D.

#### **Greene-Clay County**

Baker, Clark M. #  
 Blair, Donald Waring

Boggs, Dwight F.  
 Bonner, J. Darrell  
 Brown, Howard Stanton  
 Bulkley, William J.  
 Burchfield, Samuel S.  
 Cagle, Roger E.  
 Clark, Frank  
 Collier, Jon D.  
 Crow, Asa A.  
 D'Anna, Richard E.  
 Duckworth, Hillard R.  
 Fonticiella, Adalberto  
 Hardcastle, R. Lowell  
 Hazzard, Marion P.  
 Hendrix, Barry  
 Hendrix, Lisa  
 Hobby, George A.  
 Ilyas, Mohammad  
 Kemp, Clarence  
 Lawson, J. Larry  
 Luker, Jerome H.  
 Mitchell, Bennie E.  
 Morrison, Jimmy J.  
 Muse, Jerry L.  
 Nissenbaum, Eliot M.  
 Page, Billie C.  
 Purcell, Donald I.  
 Rich, Cheryl Darline  
 Rouse, Kevin  
 Schechter, Ron D.  
 Shedd, Leonus L.  
 Sheridan, James G.  
 Shotts, C. Mack Jr.  
 Shotts, Vern Ann  
 Smith, Norman E.  
 Watson, Samuel D.  
 White, Robert B.  
 Williams, Dwight M.  
 Williams, Jacob M.  
 Wilson, John E.  
 Ziomek, Stanley

#### **Hempstead County**

Downs, Michael  
 Harris, Lowell O.  
 Holt, Forney G.  
 Opiela, Jaroslaw P.  
 Parcon, Paul J.  
 Stevens, David G.  
 Williams, Carl L.

#### **Hot Spring County**

Berry, Frederick B.  
 Bollen, A. Ray  
 Brashears, Larry B.  
 Burton, Bruce K.  
 Cobb, Russell W.  
 Ellis, C. Randolph  
 Kersh, N. B.  
 Mayfield, Robert  
 Purifoy, Shawn  
 Tilley, Absalom

Vaughan, John A.  
 White, Bruce A.  
 White, Robert H.  
 Willingham, Cynthia

#### **Howard-Pike County**

Chuadry, Zafar A.  
 Dunn, Robert  
 Floyd, Mark A.  
 Gullett, A. Dale  
 Humphreys, T. J. Jr.  
 King, Joe D.  
 Martinazzo-Dunn, Anna  
 Peebles, Samuel W.  
 Sayre, John  
 Sykes, Robert  
 Turbeville, James O.  
 Verser, Michael  
 Ward, Hiram T.  
 White, Phillip L.

#### **Independence County**

Alexander, William Steve  
 Allen, James D.  
 Angel, Jeff D.  
 Baker, J.R.  
 Baker, Robert V.  
 Barnes, Seth Michael  
 Bates, Ronald J.  
 Beck, James F.  
 Bernard, Douglas Dean  
 Bess, Lloyd G.  
 Brown, Hunter Lee  
 Brown, Verona T.  
 Cummins, Thomas  
 Davidson, Andy  
 Davidson, Dennis O.  
 Fielder, David  
 Fowler, William  
 Goodin, William H. Jr.  
 Hays, Sarah F.  
 Jeffrey, Jay R.  
 Johnson, Deborah A.  
 Jones, Edward J.  
 Jones, Edward T.  
 Joseph, Aubrey S.  
 Ketz, Wesley J.  
 Lambert, John S.  
 Lowery, Ronald  
 Lytle, Jim E.  
 McClain, Charles M. Jr.  
 Melton, Clinton G.  
 Montgomery, F. Renee'  
 Moody, Lackey G.  
 Moody, Melody  
 Neaville, Gregory  
 O'Brien, Marcus D.  
 Piediscalzi, Nicholas  
 Scott, John G.  
 Simpson, Ronald  
 Slaughter, Bob L.



Stanton Shields, Mary Catherine  
Sutterfield, Terry F.  
Taylor, Chaney W.  
Taylor, Charles A.  
Thrasher, James R.  
Waldrip, William J. III  
Walton, Robert B.  
Webster, Russell P.  
Williams, Robin C.

### **Jackson County**

Ashley, John D. Jr. #  
Calhoun, Aris  
Chauhan, Mufiz A.  
Dudley, Guilford M. III  
Falwell, K. Wade  
Frankum, Jerry M. Jr.  
Green, Roger L.  
Hergenroeder, Paul J.  
Hunt, Randall Evan  
Jackson, Jabez Fenton Jr.  
Jones, Karen Dee  
Junkin, A. Bruce  
Poon, Hon K.  
Reynolds, Roland C.  
Snodgrass, Phillip A.  
Tan, Domingo

### **Jefferson County**

Alexander, Lester T.  
Ancalmo, Nelson  
Anderson, Charles W.  
Armstrong, Simmie Jr.  
Atiq, Omar T.  
Atkinson, Robbie  
Atnip, Gwyn  
Attwood, H. M.  
Bell, Carl H. Jr.  
Bitzer, Lon  
Bracy, Calvin M.  
Brooks, R. Teryl Jr.  
Broughton, Stephen A.  
Buckley, J. Wayne  
Buckner, Amy  
Busby, John  
Campbell, James C. Jr.  
Carlton, Irvin L. #  
Clark, Charles A.  
Coleman, Roy D.  
Crenshaw, John  
Davis, Charles M.  
Davis, Paul W.  
Dedman, John D.  
Deneke, William  
Dharamsey, Shabbir A.  
Duckworth, Thomas S.  
Dunaway, Joseph D.  
Fendley, Ann E.  
Fendley, Herbert F.  
Flowers, Martha A.  
Forestiere, Lee A.

Frigon, Jacquelyn S.  
Gardner, Dan R.  
Garner, Kimberly  
Gordon, Anthony  
Green, Horace L.  
Gullett, Robert R. Jr.  
Harris, John E.  
Harvey, Jerry L.  
Holaday, Lisa M.  
Hughes, L. Milton  
Hussain, Shafqat  
Hutchison, E. L.  
Hyman, Carl E.  
Irwin, Raymond A. Jr.  
Jacks, David C.  
Jacks, Dennis  
James, William J.  
Jenkins, Bobby  
Jenkins, Mary Ellen  
Jones, James III  
Justiss, Richard D.  
Kabani, Noor  
Krupala, James Lee  
Langston, Lloyd G.  
Ligon, Ralph E.  
Lim, William N.  
Lindsey, James A.  
Lum, Don  
Lupo, David A.  
Lytle, John O.  
Mabry, Charles D.  
Madera, George J.  
Malik, Shamim A.  
Marcus, Herschel  
Marfatia, Vikram S.  
McDonald, Robert L.  
Meredith, William R.  
Middleton, Toni L.  
Miller, Donald L.  
Miller, Joseph E.  
Milligan, Monte C.  
Mohiuddin, Mohammed J.  
Morris, Gerald C.  
Newan, Michael  
Nixon, David T.  
Nixon, William R.  
Nuckolls, J. William  
Over, Darrell R.  
Pearce, Malcolm B.  
Pierce, J. R. Jr.  
Pierce, Reid  
Pierce, Ruston Y.  
Pollard, J. Alan  
Quimosing, Estelita M.  
Redman, Anna T.  
Reid, Lloyene B.  
Roaf, Sterling A.  
Roberson, George V. Jr.  
Robinson, Paul F.  
Rogers, Henry L.  
Ross, Robert L.  
Samuel, Ferdinand K.

Sangoseni, Abiodun  
Shorts, Stephen D.  
Shrum, Kelly  
Simmons, Calvin R.  
Simpson, P. B. Jr.  
Smith, Paul L.  
Stern, Howard S.  
Sullenberger, A. G.  
Tejada, Ruben  
Townsend, Thomas E.  
Tracy, C. Clyde  
Trice, James  
Walajahi, Fawad H.  
Washington, Erma  
Wineland, Herbert L.  
Worrell, Aubrey M. Jr. #

### **Johnson County**

Goodman, James David  
Kuykendall, Scott  
McKelvey, Richard  
Pennington, Donald H.

### **Lafayette County**

Harbin, Bradley  
Lee, Willie J.

### **Lawrence County**

Davidson, Charles D.  
Hughes, Joe E.  
Joseph, Ralph F.  
Lancaster, Shawn  
Lancaster, Ted S.  
Quevillon, Robert D.  
Spades, Sebastian A. III  
Vellozo, Paul

### **Lee County**

Balke, Susan W.  
Gray, Dwight W.  
Ly, Duong N.  
Ly, Phuong  
Waddy, Leon Jr.

### **Little River County**

Covert, George K.  
Kile, H. Lawson Jr.  
Kleinschmidt, Kevin C.  
Vorhease, James W.

### **Logan County**

Ahmed, Sahibzada  
Alexander, Eugene  
Borklund, Maurice K.  
Buckley, Douglas A.  
Daniel, William R.  
Enns, Wayne P.  
Harbison, James D.  
Richey, Jason D.

### **Lonoke County**

Abrams, Joe A.

Anderson, Leslie  
Blair, Ruth Ann  
Braswell, Thomas  
Holmes, Byron E.  
Inman, Fred C. Jr.  
Merritt, James M.  
Paslidis, Nick J.  
Rochelle, Joe  
Schumann, Gerald M.  
Shurley, Floyd Jr.  
Wycoff, Robert M.

### **Miller County**

Alkire, Carey  
Andrews, A. E. Jr.  
Barnes, Walter C. Jr.  
Bigongiari, Lawrence R.  
Blankenship, D. Michael  
Burns, Billy R.  
Campanini, D. Scott  
Carlisle, David L.  
Dildy, Edwin V. Jr.  
Ditsch, Craig E.  
Dodd, N. Leland  
Dodge, John M.  
Duncan, Donald L.  
Ford, John Suffern  
Fox, Thomas  
Franks, Hayden  
Gabbie, Mark  
Graham, John  
Green, R. Clark  
Griffin, Nancy  
Hollingsworth, Charles E. II  
Jean, Alan B.  
Jones, John W.  
Joyce, F. E.  
Kittrell, James  
Knowles, Stanley C.  
Loe, Arlis W.  
McGinnis, Robert S. Jr.  
Morris, Howard  
Norris, John A.  
Peebles, Larry M.  
Robbins, Joseph  
Robertson, William J.  
Rountree, Glen A.  
Royal, Jack L.  
Sarrett, James  
Schmidt, Howard  
Shipp, G. Carl  
Smith, Arnett D. Jr.  
Solomaz, Gregory J.  
Solomon, J. Alan  
Somerville, Patrick J.  
Spence, Shanna  
Stringfellow, Jerry B.  
Stussy, Shawn  
Thomas, Jeffory  
Vereen, Lowell E.  
Wade, Billy  
Wilhelm, Frieda

Wren, Herbert B.  
Wright, Nathan L.  
Yarbrough, Charles P.  
Young, Mitchell

### Mississippi County

Abraham, Anes Wiley  
Abramson, Lawrence  
Anderson, Laurie Jean  
Bell, Mary C.  
Biggerstaff, Jerry  
Brock, Charles C. Jr.  
Butler, Judith Arlene  
Cullom, Sumner R.  
Fairley, Eldon  
Fergus, R. Scott  
Hester, Karen Calaway  
Hester, Richard  
Hubener, Louis F.  
Hudson, James H.  
Husted, G. Scott  
Jones, Herbert  
Jones, Joe V.  
Lin, Ching-Shan  
LoCascio, Paul A.  
Marcus, Trent Wright  
Osborne, Merrill J.  
Pollock, George D.  
Rhodes, Joseph  
Rodman, T. N.  
Russell, James D.  
Shahriari, Sia  
Shaneyfelt, E. A.  
Smith, Ronald D.  
White, John S.  
Williams, John S.

### Monroe County

Campos, Amador  
Collins, Linda  
David, Neylon C. Jr.  
Pham, Dac Tat  
Pupsta, Benedict F.  
Stone, Herd E. Jr.  
Walker, Walter L. #

### Ouachita County

Abbott, Judy  
Blagdon, Donald G.  
Braden, Lawrence F.  
Brunson, Milton  
Crump, Mark R.  
Daniel, William A.  
Dedman, William D.  
Floss, Robert  
Fohn, Charles H.  
Guthrie, James  
Hartman, Raymond P.  
Hout, Judson N.  
Jameson, John B. Jr.  
Kelly, Patricia  
Kendall, Jerry R.

Martin, Dan  
McFarland, Gale  
Mosley, David  
Nunnally, Robert H.  
Ozment, L. V.  
Shrestha, Bal Narayan  
Thorne, Arthur E.

### Phillips County

Athota, Prasad J.  
Barrow, John H. Jr.  
Bell, L. J. Patrick  
Bell, L. J. Patrick II  
Berger, Alfred A. #  
Epstein, S. Mitchell  
Faulkner, Henry N.  
Frederick, William Ronald  
Hall, Scott  
McCarty, Gordon E. Jr.  
McDaniel, Marion A.  
Miller, Robert D. Jr.  
Paine, William T.  
Patton, Francis M.  
Rangaswami, Bharathi  
Rangaswami,  
Narayanaswami  
Reddy, Vijayabhasker  
Tukivakala, P. Reddy  
Vasudevan, Kanaka  
Vasudevan, P.  
Webber, David L.  
Winston, William II  
Wise, James E. Jr.

### Polk County

Beckel, Ron Jr.  
Finck, John Henry  
Fried, David D.  
Henning, Theodore J.  
Lamb, Johnny Mack  
Lochala, Richard  
Mesko, John D.  
Perry, Karen A.  
Sosa, Humberto J.  
Tinnesz, Thomas  
Wood, John P.

### Pope County

Allison, Russell  
Ashcraft, Ted  
Austin, Nathan  
Bachman, David S.  
Barron, William G.  
Barton, A. Dale  
Battles, Larry D.  
Beavers, H. Kevin  
Bell, Michael  
Bell, Robert A.  
Berner, Dennis W.  
Birim, Patricia J.  
Bradley, Stanley C.  
Brown, Charles H.

Brown, William Bruce  
Burgess, James G.  
Callaway, Jody C.  
Carter, James M.  
Cloud, Joe A.  
Crouch, James Jr.  
Crumpler, Joe B. Jr.  
Duffield, Robin P.  
Dunn, Donald L.  
Ewing, Donald C.  
Ezell, Gerry D.  
Ferris, Craig A.  
Galloway, William W.  
Gately, Stanley  
Haines, Lynn  
Hale, Jeffrey  
Harden, V. Anthony  
Harrison, Rick  
Henderson, Vickie L.  
Hendren, Mike  
Hill, Donald F.  
Hines, Cynthia R.  
Honghiran, Ted  
Johnson, Carroll  
Jones, Charles Jr.  
Kerin, Douglas  
Khan, Muhammad A.  
Killingsworth, Stephen M.  
King, John W.  
King, W. Ernest Jr.  
Kolb, James M. Jr.  
Kriesel, Ben J.  
Lawrence, Frank M.  
Lee, John R.  
Lovell, Richard K. Sr.  
Lowrey, Douglas H.  
Lowther, Laura Marie  
Luzietti, Nicholas P.  
Massey, V. Rudolph  
Mauch, E. Jane  
May, Robert H. Jr.  
McCraw, Barry W.  
Meyer, Kelly H.  
Monfee, Andrew M.  
Murphy, David S.  
Myers, Gary Dean  
Myers, J. Mark  
New, Kenneth O.  
Pilkington, Neylon S.  
Price, Larry  
Richison, George C.  
Riddell, C. Michael  
Riley, Don C.  
Smith, Lynette  
Sosebee, William S.  
Soto, Sergio F.  
Stolz, Gerald A. Jr.  
Tapley, Thomas S.  
Teeter, Stanley D.  
Thurlby, W. Robert  
Turner, Finley P. II  
Turner, Kenneth B.

West, Boyce W.  
White, Ronald  
Wilkins, Charles F. Jr.  
Williams, David M.  
Williams, Thomas C.  
Young, Charles

### Pulaski County

Abel, Lee C.  
Abraham, Dana C.  
Abraham, James H. III  
Abraham, James H.  
Ackerman, William E. III  
Adametz, James  
Adametz, John Sr.  
Adametz, John Jr.  
Adametz, Kimberly  
Adams, Christopher  
Adamson, James  
Alexander, Albert S.  
Alford, T. Dale #  
Allen, Durward Jr.  
Allen, John E. Jr.  
Alston, Phillip  
Angtuaco, Edgardo  
Angtuaco, Edward E.  
Aquino, Al  
Araoz, Carlos  
Archer, Robert L.  
Arrington, Robert  
Atha, Timothy C.  
Atkinson, Evangelina  
Baber, John C.  
Baber, John T.  
Bailey, H. A. Ted Jr.  
Baker, Glen F.  
Baker, John W.  
Baker, Johnson  
Baldwin, Maxwell R.  
Baldwin, Shelly  
Baltz, Brad Patrick  
Baltz, Katherine  
Barber, Jeffrey  
Barber, Laurie  
Bard, David S.  
Barger, Denver L.  
Barlow, Brian E.  
Barnes, C. Lowry  
Barnes, Reginald  
Barnes, Robert W.  
Barnett, David  
Barron, Edwin N. Jr.  
Barrow, Robert  
Bartnicke, Benjamin J.  
Barton, Gary  
Baskin, Barry  
Bates, Joseph H.  
Bates, Ramona L.  
Bates, Stephen  
Bauer, David  
Bauer, F. Michael  
Bauer, Frank M. Jr.



Bauman, David C.	Buchman, Joseph K.	Cooper, Keith W.	Fernandez, Agustin
Bayliss, John M.	Bucolo, Anthony P.	Cope, Michael	Ferris, Ernest J.
Beadle, Beverly	Buford, Joe L.	Corbitt, Mary	Fewell, Ronald D.
Bearden, James R.	Burba, Alonzo R.	Cornell, Paul J. #	Fielder, Charles R.
Beaton, J. Neal	Burger, Robert A.	Courtney, Willis Jr.	Finan, Barre F.
Beau, Scott	Burks, Karen	Coussens, David M.	Fincher, Robert L.
Beck, Joseph II	Burnett, Hugh F.	Covey, M. Carl Jr.	Fiser, Martin
Becquet, Norbert J.	Burrow, Dennis R.	Crews, J. Travis	Fiser, Robert H. Jr.
Belknap, Melvin L.	Bursey, Deborah Lee	Crocker, Charles H.	Fiser, William P. Jr.
Bell, Rex H.	Byrum, Jerry	Cross, J. B.	Fitzgerald, Charles
Bennett, Anita	Calcote, Robert A.	Crow, Joe W.	Fitzhugh, A. Stuart
Bennett, F. Anthony Jr.	Calderon, Vincent Jr.	Crow, R. Lewis Jr.	Flamik, Darren E.
Benton, William	Caldwell, Charles R.	Darwin, William G.	Flaming, Jay
Berry, Robert L.	Calhoon, J. Dale	Daugherty, Joe D.	Fletcher, Anthony
Bevans, David III	Calhoun, Joseph D.	Daugherty, John L.	Fletcher, Thomas M.
Bevans, David W. Jr.	Calhoun, Richard A.	David, Alex	Florez, James P.
Bienvenu, Gregory	Campbell, Gilbert S.	Davie, Melanie	Floyd, Bill G.
Bienvenu, Harold G. III	Campbell, James W.	Davila, David G.	Ford, Barry G.
Bierle, Michael	Caplinger, Kelsy J. III	Davis, J. Lynn	Foster, Gil
Billie, James	Carfagno, Jeffrey	Davis, Scott A.	Fraiser, Lacy P.
Biondo, Raymond V.	Carle, Scott W.	Day, James A.	France, Gene L.
Birkett, Ian McRae	Carson, Layne E.	De Bruyn, Van H.	Fraser, Eric A.
Bishop, William B.	Carter, Jerry L.	DeLoach, John Jr.	Fravel, Jonathan F.
Blackshear, Jack L. Jr.	Carttar, Charles	Dean, David M.	Frazier, Cynthia
Blankenship, William F.	Caruthers, Carol	Dean, David P.	Frazier, G. Thomas
Blasier, R. Dale	Caruthers, Samuel B. Jr.	Dean, Gilbert O.	Freeman, Diane
Boehm, Timothy	Casali, Robert E.	Deaton, C. William Jr.	Fuller, C. Dale
Boellner, Samuel W.	Cash, Darlene	Deed, Ashley	Fuller, C. James III
Boger, James E.	Casper, Robert B.	Deer, Philip J. Jr.	Fulmer, John M.
Boop, Bradley Scott	Casteel, Helen	Deer, Philip James III	Galbraith, Robert C.
Boop, Warren C. Jr.	Cate, Chris M.	Delap, Susan	Gardner, Guy F.
Bornhofen, John H.	Cathey, Janet	Dennis, James L.	Garner, William L.
Bost, Roger B.	Cathey, Steven	DesLauriers, S. Killeen	Gehl, Jerome
Bourne, David E.	Chakales, Harold H.	Dickins, John R. E.	Gettys, Joseph M. Jr.
Bowen, Timothy	Chandler, Kay H.	Dickins, Robert D. Jr.	Gibbs, Mark
Bowen, W. Scott	Chappell, Carol W.	Dillard, Daniel C.	Gibson, Gordon L.
Bower, Charles M.	Chatelain, Stephen M.	Diner, Bradley	Giglia, Anthony R. III
Boyd, Charles M.	Cheairs, David B.	Dixon, Keith A.	Giles, Wilbur M.
Bradburn, Curry B. Jr.	Cheairs, John T.	Dodd, Doyne	Gillespie, A. Tharp
Bradford, J. David	Chesser, Michael Z.	Domon, Steven E.	Gillespie, John Newton
Bradley, Joe F.	Chisholm, Dan P.	Doucet, Marlon J.	Gilliam, David
Brainard, Jay O.	Choate, Robert B.	Douglas, Warren M.	Gist, Charles C.
Breau, Randall L.	Christian, John D.	Downs, Ralph A.	Glasco, Gerry B.
Bressinck, Renie E.	Christy, George W.	Driskill, Angela	Glenn, Wayne B.
Brewer, Robert	Chudy, Amail	Duke, Anton L.	Glover, Lawson E. Jr.
Brimberry, Ronald K.	Church, Marion M.	Dungan, William T.	Glover, W. Clyde
Brineman, John	Clark, Richard B.	Dunnagan, Steven A.	Golden, William E.
Brinkley, Roy A.	Clark, Robert B.	Dwyer, Gregory A.	Goldsmith, Geoffrey
Brizzolara, A. J.	Cleveland, Elton	Eans, Thomas L.	Gosser, Bob L.
Brizzolara, John Paul	Clift, Steven A.	Easter, Rex M.	Goza, Gary R.
Broach, R. Fred	Clifton, Cliff	Edge, Otis H.	Goza, George M. Jr.
Broadwater, John Ralph Jr.	Clogston, Charles W.	Edmiston, Frank G.	Graham, Donna M.
Brown, Michael	Cobb, Jock S.	Edwards, Louis Jerry	Graham, Richard
Brown, Pamela S.	Cockrill, H. Howard Jr.	Eisenach, R. Jeffrey	Grant, Karen G.
Brown, Randel	Colclasure, Joe B.	English, Jim	Green, Benny J.
Browning, Donald G.	Collins, David	Evans, Billy	Green, Cheryl
Browning, Stanley K.	Collins, Gary James	Evans, Samuel C.	Greenway, C. Don
Bruce, Thomas A.	Collins, Kevin J.	Farmer, Joseph F.	Greenwood, Denise R.
Bruffett, Wayne L.	Colwell, Karen Louise #	Farque, Greg L.	Greer, G. Stephen
Bryan, James W. IV	Cone, John	Fasules, James	Greutter, John E. Jr.
Buchanan, Francis R.	Cook, J. Mitchell	Fenton, Ronnie M.	Griebel, Jack A. Jr.
Buchanan, Gilbert A.	Cook, Timothy R.	Ferguson, Max Ann	Griffin, David

Grimes, H. Austin  
 Guard, Peggy K.  
 Guggenheim, Frederick G.  
 Guin, Jere D.  
 Hagler, James L.  
 Hahn, Herbert L.  
 Hall, A. D.  
 Hall, A. David  
 Hall, Gregory S.  
 Hall, R. Whit  
 Hamilton, George Jr.  
 Hampton, John R. III  
 Hankins, Edwin III  
 Hanna, Ehab  
 Harber, Harley  
 Hardberger, R. E.  
 Hardin, Robert  
 Hardin, Ronald D.  
 Harger, C. Harold  
 Hargrove, Joe L.  
 Harms, Steven E.  
 Harper, Gary E.  
 Harrell, James Jr.  
 Harrendorf, Cagle  
 Harrington, G. Scott  
 Harrington, Mariann  
 Harris, Donald R.  
 Harris, Nita  
 Harris, T. Stuart  
 Harris, W. Turner  
 Harrison, A. Vale  
 Harrison, Roy E.  
 Harrison, William  
 Harshfield, David Lee Jr.  
 Hart, Thomas M.  
 Harter, Scott  
 Hatch, Allan B.  
 Hathcock, Stephen A.  
 Hauer-Jensen, Martin  
 Hayden, William F.  
 Hayes, J. Harry Jr.  
 Hayes, John  
 Hayes, Richard L.  
 Hayes, Sidney P.  
 Haynes, W. Ducote  
 Headstream, James W.  
 Hearnberger, H. Graves III  
 Hearnberger, Henry G. Jr.  
 Hearnberger, John E.  
 Heaton, Keith M.  
 Hedges, Harold IV  
 Hedges, Harold H.  
 Hefley, Bill F. Sr.  
 Hefley, William F. Jr.  
 Heifner, John K.  
 Henker, Fred O. III  
 Henry, C. Reid Jr.  
 Henry, D. Andrew  
 Henry, G. Michael  
 Henry, G. Morrison  
 Henry, J. Charles  
 Henry, J. Forrest Jr.

Henry, Richard Y.  
 Henry, W. Bradley  
 Henry, William T.  
 Herring, Grady Jr.  
 Herron, Jerry M.  
 Hickey, Joseph P.  
 Hicks, David C.  
 Hicks, David L.  
 Hixson, Marcia Lynn  
 Hodges, J. Timothy  
 Hoffmann, Thomas H.  
 Holland, Jay D.  
 Holloway, J. Douglas  
 Holt, Stephen  
 Holton, Jerry C.  
 Hopkins, Karmen  
 Horn, Thomas Dag  
 Hough, Aubrey J. Jr.  
 Houk, Richard  
 Houston, Samuel  
 Howell, Coburn S. Jr.  
 Hubach, Cindy  
 Hudec, Regina  
 Hughes, Ronald D.  
 Hundley, Randal F.  
 Hutchins, Laura  
 Hutchins, Steven W.  
 Hutson, Harold G.  
 Ibsen, Michelle J.  
 Ingram, Jim  
 Ironside, J. Brett  
 Jackson, J. Presley  
 Jackson, Richard J.  
 Jansen, G. Thomas  
 Jenkins, Bradley  
 Johns, Richard D.  
 Johnson, Anthony D.  
 Johnson, B. Richard  
 Johnson, Ben D.  
 Johnson, Carl  
 Johnson, Clifton R.  
 Johnson, Dianne Flowers  
 Johnson, M. Bruce  
 Johnson, Philip H.  
 Johnston, Dale E.  
 Johnston, Kenneth  
 Jones, Gail Reede  
 Jones, Garry L.  
 Jones, John C.  
 Jones, Robert D.  
 Jones, Roy Steven  
 Jones, S. Michael  
 Jones, William N.  
 Jordan, F. Richard  
 Jordan, Randy A.  
 Joseph, Ralph F. II  
 Joseph, William Frank  
 Jouett, W. Ray  
 Joyce, John W.  
 Junkin, Ruth H.  
 Kaemmerling, Raymond E.  
 Kagy, Lori Michelle

Kagy, Matthew  
 Kahn, Alfred Jr.  
 Kane, James J.  
 Karageanes, Steven  
 Keeran, Michael G.  
 Keith, Sharon C.  
 Kellar, Stanley L.  
 Keller, Alfred W.  
 Kennedy, Eleanor E.  
 Kennedy, H. Frazier  
 Kennedy, Robert  
 Keplinger, Florian  
 Ketcham, Jeffrey  
 Key, J. Michael  
 Kidd, Tracy L.  
 Kilgore, Erik J.  
 Kilgore, Reed W.  
 King, Michael T.  
 King, W. David  
 Kiser, Thomas  
 Kittler, Fred J.  
 Kizziar, Jim C.  
 Klimberg, V. Suzanne  
 Knott, Patricia A.  
 Knox, Michael F.  
 Kolb, Agnes J.  
 Koonce, Thomas W.  
 Kovalski, Thomas M.  
 Krulin, Gregory S.  
 Kuhn, Ronald  
 Kulik, Steven A.  
 Kumpuris, Andrew G.  
 Kumpuris, Frank G.  
 Kusenberger, Don Levi  
 Kyser, J. Floyd  
 Laakman, Robert W.  
 Lambert, Robert A.  
 Landers, James H.  
 Lane, John W.  
 Lang, Nicholas P.  
 Langford, Timothy  
 Lawton, Andrew William  
 Lehmberg, Robert W.  
 Leibovich, Marvin  
 Leithiser, Richard Jr.  
 Leonard, Donald G.  
 Leou, Frank J.  
 Lewis, Derek  
 Lile, Henry A.  
 Lincoln, Ben M.  
 Lipke, Jay M.  
 Loeb, Edward C.  
 Logan, Charles W.  
 Lomax, Lorene  
 Love, Tommy L. Jr.  
 Lowe, Betty A.  
 Lu, Eugene  
 Lucy, Vincent  
 Ludwig, Frank R.  
 Luttrell, Rex E.  
 Lyle, Carlene W.  
 Lyons, Virgle E. Jr.

Ma, Frank  
 Mabrey, William  
 Magie, Stephen K.  
 Mallory, John A.  
 Maloney, F. Patrick  
 Maners, Ann  
 Markland, Gary S.  
 Marks, Stephen R.  
 Marotti, A. Scott  
 Martin, Kenneth A.  
 Marvin, Peter  
 Mason, J. Zachary  
 Mason, William L.  
 Matthews, Joseph W.  
 McCarthy, Richard E.  
 McCasland, Leslie D.  
 McConnell, John D.  
 McCoy, Julia M.  
 McCracken, Gail Ann  
 McCracken, John  
 McCrary, George A.  
 McDonald, James E.  
 McDonald, Judy  
 McGhee, Judith E.  
 McGhee, Michael A.  
 McGowan, Robert Jr.  
 McGrew, Robert N.  
 McKelvey, K. David  
 McKnight, C. Allen  
 McLaughlin, Shannon  
 McLeane, Mark  
 McNeel, Valerie  
 Meacham, Donald F.  
 Meador, Annette Parker  
 Meadors, Carol  
 Meadors, Frederick  
 Meadors, John  
 Medlock, Rickey D.  
 Mego, David Michael  
 Mellor, Roy II  
 Melton, Christopher  
 Mendelsohn, Lawrence A.  
 Merritt, Mathew  
 Meziere, Tom  
 Miles, David A.  
 Miller, Forrest B. Jr.  
 Miller, Michael  
 Miller, Raymond P. Sr.  
 Milligan, L. Beth  
 Milner, E. L.  
 Mitchell, George K.  
 Mitchell, Katherine B.  
 Mizell, Philip  
 Mizell, Walter S.  
 Moffett, T. Robert Jr.  
 Money, Wandal D.  
 Montanez, Josue  
 Mooney, Donald K.  
 Moore, Burton A.  
 Moore, J. Malcolm Jr.  
 Moore, Michael  
 Moore, Rex N.



Moore, Robert B.  
 Moore, Thomas C.  
 Morris, Barbara  
 Morris, W. Dale  
 Morrison, Debra F.  
 Morse, James C.  
 Morton, William J.  
 Mulhollan, James S.  
 Murphy, Bruce  
 Murphy, Jeanne  
 Murphy, Randolph  
 Murphy, Robert  
 Murphy, Tena  
 Nagel, Fred G.  
 Nair, Balan A.  
 Napolitano, Charles A.  
 Nash, John C.  
 Nelson, Alvah J. III  
 Nelson, Carl L.  
 Newbern, D. Gordon  
 Newsum, Jon Kirby  
 Newton, Fred E.  
 Nguyen, Duong  
 Nichols, Sandra D.  
 Nix, Richard A.  
 Nokes, Steven  
 Norton, George A.  
 Norton, J.B. Jr.  
 Norton, Joseph A.  
 Nowlin, James Bill  
 Nugent, Richard  
 Nutt, Angela  
 O'Neal, James Franklin  
 Ochoa, Eduardo R. Jr.  
 Oddson, Terrence A.  
 Oglesby, Walter R.  
 Osam, Patrick N.  
 Overacre, Robert  
 Owen, Kip  
 Owen, Richard Jr.  
 Owings, Richard  
 Padberg, Frank T.  
 Paddock, George  
 Padilla, Fernando  
 Palmer, Hal  
 Pappas, James J.  
 Parham, David M.  
 Parker, J. Mayne  
 Parker, Ray K.  
 Parkhurst, James  
 Parmley, Tim  
 Parnell, Clifton L. III  
 Pastor, Randy  
 Patel, Kamal  
 Patrick, Larry L.  
 Paulus, Thomas E.  
 Peal, Gabriel M.  
 Pearce, Charles E.  
 Peek, Richard  
 Peoples, R. Earl  
 Perser, Elwyn  
 Peters, John E.

Peters, Phillip J.  
 Petrus, Gary M.  
 Petursson, Gissur J.  
 Pevahouse, Joe  
 Phillips, Charles E.  
 Phillips, Hannah  
 Phillips, John D.  
 Pierce, William  
 Pike, John D.  
 Pledger, Norman R.  
 Pollard, Arlee E.  
 Pollock, Michael Marion  
 Pope, Christopher H.  
 Pope, Norton A.  
 Porter, Robert A. Jr.  
 Potts, Jerry L.  
 Power, Robert C.  
 Prather, Jerry L.  
 Pringos, Andrew A.  
 Pruitt, Tad  
 Pyle, Hoyte R. Jr.  
 Pyne, Jeffrey M.  
 Quinn, Brian D.  
 Ransom, John M.  
 Rapp, Richard J.  
 Raque, Carl J.  
 Rayburn, Samuel T.  
 Rector, Nancy F.  
 Redding, Allen H.  
 Reddy, Yeshwant  
 Reding, David L.  
 Redman, John F.  
 Reed, Ewing C. Jr.  
 Reese, William G.  
 Reid, Gene W.  
 Remmel, Raymond  
 Rice, James Curtis  
 Rice, Robert L.  
 Riddle, John F. Jr.  
 Riley, William H.  
 Ritchie, Robert Ross  
 Robbins, Kenneth  
 Roberson, Michael C.  
 Roberts, Kevin  
 Rodgers, C. Dudley  
 Rodgers, Charles H.  
 Rogers, Rachel M.  
 Roman, Anthony  
 Rooney, Thomas P.  
 Rosenbaum, Carl A.  
 Ross, Ashley Sloan  
 Ross, Cynthia  
 Ross, S. William  
 Rounsaville, Harry L.  
 Roy, F. Hampton  
 Rozas, David  
 Ruddell, Deanna N.  
 Ruggles, Dwayne L.  
 Russell, Anthony E.  
 Ryals, Rickey O.  
 Saer, Edward H. III  
 Safiman, Bruce L.

Sanders, Kelli Keene  
 Sanderson, M. Bruce  
 Sangster, Michael  
 Santoro, Ian H.  
 Satre, Richard W.  
 Schlesinger, Scott Michael  
 Schock, Charles C.  
 Schratz, Bruce E.  
 Schroeder, George T.  
 Schultz, Charles E.  
 Schultz, John C.  
 Schwander, L. Howard  
 Schwankhaus, John D.  
 Scott, Jane F.  
 Scruggs, Jan W.  
 Searcy, Robert M.  
 Seguin, Rosey  
 Seibert, Robert  
 Selakovich, Walter G.  
 Sessions, Louis II  
 Shaw, Robert Haley  
 Shewmake, Kristopher B.  
 Shields, Eddie  
 Shock, John P.  
 Shock, Melessa  
 Short, Harold K.  
 Shotts, Joseph  
 Shrieve, Dennis Charles  
 Shuffield, James  
 Siems, Martin  
 Silvos, Gerald R.  
 Silzer, Robert R.  
 Simmons, Debra Lynn  
 Simmons, Orman W.  
 Simpson, Steve  
 Sims, James M.  
 Singer, Peter  
 Singleton, L. Gene  
 Sipes, Frank M.  
 Sitarik, Kathleen  
 Sitz, Karl V.  
 Skokos, C. Kemp  
 Slater, John G. Jr.  
 Slaven, John E.  
 Slayden, John E.  
 Sloan, Eugene E.  
 Sloan, Fay M.  
 Smart, Douglas F.  
 Smelz, Johnny  
 Smith, Aubrey C.  
 Smith, Charles W.  
 Smith, David E.  
 Smith, Douglas B.  
 Smith, G. Richard Jr.  
 Smith, J. Tom  
 Smith, James L.  
 Smith, Melanie Herrold  
 Smith, Purcell Jr.  
 Smith, Samuel D.  
 Smith, Thomas J.  
 Smith, Thomas W.  
 Smith, Vestal B. Jr.

Snyder, Douglas Scott  
 Snyder, Victor F.  
 Somers, A. Jack Jr.  
 Sorrells, R. Barry  
 Sotomora, Ricardo F.  
 Squire, Arthur E. Jr.  
 St Amour, Thomas E.  
 Stair, J. Michael  
 Stallings, James Walt  
 Stanley, Joe P.  
 Stefans, Vikki Ann  
 Stephens, Wanda  
 Stern, Scott J.  
 Sternberg, Jack J.  
 Stewart, Bobby Ray  
 Stewart, Daryl  
 Stinnett, Thomas  
 Stokes, B. Douglas  
 Storeygard, Alan R.  
 Stotts, John R.  
 Stout, Kimber  
 Stout, Michael D.  
 Strauss, Mark A.  
 Stringer, Warren  
 Strode, Steven W.  
 Stroope, George F.  
 Studdard, James D.  
 Sturdivant, Stephen  
 Suen, James  
 Sullivan, Charles D.  
 Sullivan, Jan R.  
 Sundermann, Richard H.  
 Suphan, Neema A.  
 Talbert, Gary Eugene  
 Talbert, Michael L.  
 Tamas, David E.  
 Tanner, James A.  
 Taylor, David R.  
 Taylor, Eugene H.  
 Taylor, Ken M.  
 Taylor, Martin A.  
 Tedford, John G.  
 Tharp, John G.  
 Thomas, A. Henry  
 Thomas, Peter O.  
 Thomason, Steven L.  
 Thompson, S. Berry Jr.  
 Thorn, G. Max  
 Tilley, Steve  
 Tolleson, Claudia  
 Towbin, Eugene J.  
 Tracy, Phillip A.  
 Trantum, Bill L.  
 Trigg, Laura  
 Tseng, Jyi-Ming  
 Tucker, R. Stephen  
 Tucker, W. Everett  
 Valentine, Robert G. Jr.  
 Van Zandt, Janelle  
 Velez, Duane  
 Vinsant, Kurtis  
 Vogel, Robert G.

Wade, William I. Jr.  
 Wagoner, Jack  
 Walker, Lee  
 Walker, Ronald  
 Walt, James R.  
 Waner, Milton  
 Ward, Harry P.  
 Ward, Thomas  
 Washington, Mitzi A.  
 Watkins, Charles J.  
 Watkins, John Jr.  
 Watkins, John G. III  
 Watkins, Julia  
 Watkins, Larry S.  
 Watson, Daniel W.  
 Weber, Edward R.  
 Weber, Michael  
 Weiss, David W.  
 Weiss, Gerald N.  
 Welch, Samuel Bradley  
 Wellons, James A. Jr.  
 Wende, Raymond A.  
 Wenger, Carl E.  
 West, Joseph  
 Westbrook, Kent C.  
 Westbrook, September  
 Westerfield, Frank M. Jr.  
 Westerfield, Robert  
 Westfall, Christopher T.  
 Whiteside-Michel, Julia  
 Wilcox, Linda G.  
 Wilkes, Elbert H.  
 Wilkes, T. David I.  
 Williams, Alonzo D.  
 Williams, C. David  
 Williams, G. Doyne Jr.  
 Williams, Paul E.  
 Williams, Ronald N.  
 Williamson, Adrian III  
 Wills, Pamela  
 Wilson, Elaine  
 Wilson, Frances C.  
 Wilson, Frank J. Jr.  
 Wilson, I. Dodd  
 Wilson, James W.  
 Wilson, John L.  
 Wolverton, John  
 Workman, W. Wayne  
 Worley, Linda  
 Wortham, Thomas H.  
 Wyatt, D. Neal  
 Wyatt, Richard A.  
 Wylie, Paul  
 Yamauchi, Terry  
 Yeager-Bock, Angy  
 Yee, Suzanne  
 Yocum, John  
 Young, Douglas E.  
 Young, Evelyn  
 Zelnick, Paul  
 Ziller, Stephen A. III

**Randolph County**

Baltz, Albert L.  
 Barre, Hal S.  
 DeClerk, Thomas  
 Guntharp, George  
 Hall, Jeffrey  
 Holt, Danny B.  
 Jansen, Andrew J. III  
 Smith, Norman K.  
 Troxel, Roger  
 Warner, Robert L. Jr.

**Saline County**

Albey, Mark  
 Baber, Quin M.  
 Baka, John V.  
 Beard, Michael R.  
 Bethel, James  
 Boyle, Ronald H.  
 Brashears, Clay  
 Burton, Charles R.  
 Caldwell, David L.  
 Cartaya, Daniel I.  
 Cash, Ralph D.  
 Cathcart, Evelyn  
 Coker, S. Dale  
 Cooper, James B.  
 Council, Robert A. Jr.  
 Dixon, Jerry W.  
 Dockery, Melissa  
 Duncan, J. Shelby  
 Eaton, James M.  
 Enderlin, Annette  
 Harper, Donald  
 Higginbotham, Michael  
 Hill, Edward B.  
 Hill, Howell V.  
 Hogue, F. Paul  
 Kirk, Marvin N. Jr.  
 Martindale, J. L.  
 Martindale, Mark A.  
 Pandit, Sudhir K.  
 Quade, Deborah  
 Ramsay, Rex C. Jr. #  
 Schally, Gordon R.  
 Schmidt, Michael J.  
 Stanford, Royce Allan Jr.  
 Steele, William L.  
 Sudderth, Brian F.  
 Taggart, Sam D.  
 Thibault, Frank G. Jr.  
 Thomas, Bill R.  
 Thorn, Harvey Bell Jr.  
 Tilley, Roger L.  
 Ulmer, Stacy L.  
 Vice, Mark  
 Viner, Donald L.  
 Wagner, Taylor  
 Watson, Kirk D.  
 Wright, John D.

**Sebastian County**

Acklin, Jimmy D.  
 Aclin, Richard R.  
 Al-Ghussain, Emad A.M.M.  
 Al-Refai, Fareeda Ann  
 Albers, David G.  
 Alberty, Joe  
 Aldrich, Joseph  
 Anderson, Paul  
 Armstrong, Sinclair Jr.  
 Asbury, Dale W.  
 Atkins, Jimmie G.  
 Axelsen, Nils K.  
 Bailey, Charles W.  
 Baker, Max A.  
 Balsara, Zubin  
 Barr, Marilyn  
 Barton, Lance W.  
 Basinger, Norma Smith  
 Beachy, Allen L.  
 Bean, Paul E.  
 Beene-Lowder, Hannah L.  
 Berryhill, Richard E.  
 Berumen, Mike  
 Bise, Roger N.  
 Bodiford, Gary L.  
 Bordeaux, Ronald A.  
 Bouton, Michael S.  
 Bradford, A. C.  
 Brown, Byron L.  
 Brown, James A.  
 Brown, Richard N.  
 Buie, James H.  
 Bulteman, James L.  
 Burks, Deland  
 Busby, J. David  
 Bylak, Joseph Andrew  
 Cain, Martin W.  
 Callaway, Michael  
 Capocelli, Anthony L.  
 Carson, Randall L.  
 Cassady, Calvin R.  
 Chalfant, Charles  
 Chapman, Robert K.  
 Chester, Robert L.  
 Cheyne, Thomas  
 Choby, Beth A.  
 Christopher-Harmon, Pamela  
 Coffman, Edwin L.  
 Coffman, John L.  
 Coleman, Michael D.  
 Craft, Charles  
 Crow, Neil E. Jr.  
 Culp, William C.  
 Davenport, O. Leo  
 De La Rosa, Raymond E.  
 Deaton, John M.  
 Deneke, James S.  
 Diment, David D.  
 Dorzab, Joe H.  
 Drolshagen, Leo F. III  
 Dudding, William F.

Eckes, Anne Michelle  
 Edstrom, Steven M.  
 Edwards, Gary  
 Ellis, Homer G.  
 Ennen, Randy  
 Espina, Dario Manuel  
 Farris, Paul E.  
 Feder, Frederick P. Jr.  
 Feild, T. A. III  
 Felker, Gary V.  
 Ferrell, Jeffrey  
 Fisher, Robert D.  
 Flanagan, A. Dean  
 Flanagan, Mary Clare  
 Fleck, Randolph Peter  
 Fleck, Rebecca  
 Flippin, Tony A.  
 Floyd, Charles H.  
 Floyd, Jeffrey Denton  
 Francis, Darryl R. II  
 Gaby, Cecil Walter  
 Gardner, Kenneth  
 Gast, Kristie L.  
 Gedosh, Edgar A.  
 Gill, James A.  
 Gills, Edward Larry  
 Girklin, R. Gene  
 Glendenning, Charles C.  
 Glover, D. Bruce  
 Gold, Adam  
 Goodman, R. Cole Jr.  
 Goodman, Raymond C. Sr.  
 Griggs, William L. III  
 Gwartney, Michael P.  
 Hamilton, Lance  
 Hanley, Larry L.  
 Haraway, Stuart D.  
 Harreld, Myra A.  
 Harrington, Paul T.  
 Hendrickson, Jon  
 Henry, James  
 Herren, Adrian L.  
 Hewett, Archie L.  
 Hinkle, Richard A. Jr.  
 Hoffman, John D.  
 Hoge, Marlin B.  
 Holder, Keith Franklin  
 Holmes, Williams C. Jr.  
 Hornberger, Evans Z. Jr.  
 Howell, James T.  
 Howell, Paul K. Jr.  
 Hughes, Robert P. Jr.  
 Huskison, William T.  
 Ibrahim, Manar S.A.  
 Ihmeidan, Ismail H.  
 Ingram, Ralph N.  
 Irwin, Peter J.  
 Jackson, Hugh H.  
 Jagers, Robert  
 James, Arthur M.  
 Janes, Robert H. Jr.  
 Johnson, Arthur M.



Jones, Greg T.  
 Kannout, Fareed  
 Kareus, John L.  
 Kelly, James E. III  
 Kelly, Thomas C.  
 Kelsey, J. F.  
 Keyashian, Mohsen  
 Kientz, John Jr.  
 Klopfenstein, Keith  
 Knox, Robert  
 Kocher, David B.  
 Koenig, Albert S. Jr.  
 Kradel, R. Paul  
 Kraemer, Soren R.  
 Kramer, Ralph G.  
 Kutait, Kemal E.  
 Kyle, W. Lamar  
 Lambiotte, Louis O.  
 Landherr, Edwin  
 Landrum, Samuel E.  
 Lane, Charles S. Jr.  
 Laws, Casey  
 Lee, Kent  
 Lenington, Jerry O.  
 Lewis, George L.  
 Lilly, Ken E.  
 Lilly, Kenneth E. Jr.  
 Little, Charles  
 Lockwood, Frank M.  
 Long, James W.  
 Loyd, Gregory M.  
 MacDade, Albert D.  
 Magness, Jack L. Jr.  
 Manus, Stephen C.  
 Mapes, Raelene Ann  
 Marsh, Michael A.  
 Martimbeau, Claude  
 Martin, Art B.  
 Martin, Maurice  
 Masri, Hassan M.  
 McCarty, Joseph  
 McClain, Merle  
 McClanahan, J. David  
 McEwen, Stanley R. #  
 McMinimy, Donald #  
 Miller, Robert C.  
 Miller, Robert M.  
 Miller, Shawn S.  
 Mings, Harold H.  
 Moore, Trudy J.  
 Moore-Farrell, Laura  
 Mosley, Myra C.  
 Moulton, Everett C. Jr.  
 Moulton, Everett C. III  
 Mumme, Marvin E.  
 Musick, Stanley C.  
 Muylaert, Michel  
 Nassri, Louay K.  
 Nelson, Steve B.  
 Nichols, David R.  
 Nolewajka, Andre J.  
 O'Bryan, Robert K.

Olson, John D.  
 Orten, Steven S.  
 Paris, Charles H.  
 Parker, Joel E. Jr.  
 Parker, Thomas G.  
 Passmore, Ann Kay  
 Pearce, Larry W.  
 Pence, Eldon D. Jr.  
 Pham, Thuylinh H.  
 Phillips, Don  
 Phillips, Kevin Clark  
 Pillstrom, Lawrence G.  
 Poe, McDonald Jr.  
 Poole, M. Louis  
 Post, James M.  
 Prewitt, Taylor A.  
 Price, Claire  
 Price, Lawrence C.  
 Rabideau, Dana P.  
 Raby, Paul L.  
 Rainwater, Melissa C.  
 Raymond, Thomas H.  
 Retz, Jacy  
 Rivera, Ernesto  
 Robinson, Ronald P.  
 Romero, Alfred T.  
 Russell, Debra  
 Russell, Rex D.  
 Sanders, Robert E.  
 Sanders, Robert V. III.  
 Saviers, Boyd M.  
 Schemel, William H.  
 Schkade, Paul A.  
 Schmitz, James  
 Schwarz, Julio  
 Schwarz, Paul R.  
 Seffense, Stephen J.  
 Seiter, Kenneth  
 Severns, Cyril  
 Sherrill, William M. Jr.  
 Short, Bradley Mark  
 Smith, Gerald P.  
 Smith, Kent  
 Smith, Steven Olin  
 Smith, Terrald J.  
 Snider, James R.  
 Stewart, Casey D.  
 Stewart, Jerry R.  
 Stewart, John B.  
 Stillwell, Mark  
 Sutterfield, Vikki L.  
 Swicegood, John R.  
 Tacoronti, Rudolph V.  
 Taft, Eileen  
 Taft, Eric  
 Teeter, Mark  
 Thompson, Robert J.  
 Turner, William F.  
 Van Asche, Christopher  
 Vanderpool, Roy E.  
 Vernon, Rowland P. Jr.  
 Waack, Timothy

Wallace, Kenneth K.  
 Wanker, Frank L.  
 Webb, William K.  
 Weisse, John J.  
 Wells, John D.  
 Westermann, Norman F.  
 Whitaker, John  
 Wikman, John H.  
 Wills, Paul I.  
 Wilson, Morton C.  
 Wolfe, Michael S.  
 Woods, Leon P.  
 Zufari, Munir M.

### Sevier County

Buffington, Mike  
 Devlin, Terri A.  
 Gonzalez, Floyd  
 Hoyt, Jonathan  
 Jones, Charles N.  
 Jones, Thomas  
 Richards, Juan Carlos  
 Stearns, David E.

### St. Francis County

Collins, E. Morgan Jr.  
 Conner, George  
 Fong, Fun Hung  
 Kumar, Sudhir  
 Matthews, Seniora  
 Meredith, James Jr.  
 Miller, Matthew W.  
 Patton, W. Curtis  
 Schwartz, Frank R.

### Tri County (Sharp, Izard, Fulton)

Arnold, Carl  
 Bozeman, Jim G.  
 Campos, Louis  
 Dibrell, Fredrick  
 Garner, Julea  
 Grasse, A. Meryl  
 Hennen, Floyd A.  
 Jackson, George W.  
 Krygier, Albin J. #  
 Lane, Robert C.  
 Mayfield, Michael  
 Moody, Michael N.  
 Phillips, Rebecca  
 Relyea, William V.  
 Sitzes, David Alfred  
 Sra, Surinder  
 Tatum, Harold M.  
 Tucker, Charles L.  
 Varela, Charles D.  
 Williams, Robert S.  
 Wright, Donald

### Union County

Allen, David Eugene  
 Anaya, Carlos

Anreder, Michael Barry  
 Anzalone, Gary  
 Barenberg, Andrew  
 Bevill, Gary L.  
 Booker, J. Gregory  
 Bryant, D'Orsay III  
 Carroll, Peter J.  
 Cyphers, Charles D.  
 Daniels, C. Dwayne  
 Davis, Richard K.  
 Deere, Joy #  
 Dietzen, Richard E.  
 Dixon, R. Mark  
 Dudick, Stephen  
 Duzan, Kenneth R.  
 Edmondson, C. Douglas  
 Elliott, Wayne G.  
 Ellis, Jacob P.  
 Fonticiella, Aldo V.  
 Forward, Robert B.  
 Fraser, David B.  
 Gati, Kenneth G.  
 Germann, Robert E.  
 Giller, W. John Jr.  
 Gomez, Henry L.  
 Hill, Grady Jr.  
 Holleran, John R.  
 Hopson, Deanna  
 Jenkins, Chester W.  
 Jones, Steve A.  
 Jucas, Diana T.  
 Jucas, John J.  
 Kang, Gurprem Singh  
 King, Billy D.  
 Kinslow, Ivory  
 Landers, Gardner H.  
 Massanelli, Gregg L.  
 Menendez, Moises A.  
 Mohan, Kumaran K.  
 Murfee, Robert M.  
 Ong, Tie S.  
 Pillsbury, Richard C.  
 Pirnique, Allan S.  
 Posey, Willie II  
 Ratcliff, John  
 Rogers, Henry B.  
 Sample, Dorothy C.  
 Samicki, Joseph  
 Schonefeld, Michael D.  
 Schultz, Wayne H.  
 Scurlock, William R.  
 Seale, James E. Jr.  
 Shah, Asim Ahmed  
 Smith, George W.  
 Stevens, Willis M. Jr.  
 Talley, H. Aubry  
 Tolosa, Elizabeth  
 Tommey, C. E.  
 Tommey, Robert C.  
 Turnbow, R. L.  
 Ulmer, Minna I.  
 Vogenitz, William

Warren, George W.  
Watson, Donya  
Watson, Robert A.  
Weedman, James B.  
Williamson, John R.  
Wilson, Larkin M. Jr.  
Yocum, David M. Jr.  
Zahniser, Donna J.

### Van Buren County

Belizario, Marcelino C.  
Hall, John A.  
Pearce, Charles G.  
Pineau, Greg  
Starnes, Harry

### Washington County

Albright, Spencer III  
Allen, B. Eual  
Applegate, C. Stanley Jr.  
Arnold, James A.  
Atwood, H. Daniel  
Bailey, Donald C.  
Bailey, Scott  
Baker, C. Murl Jr.  
Baker, Donald B.  
Beck, J. Thaddeus  
Beck, William A.  
Beckman, James Jr.  
Billingsley, John A. III  
Blankenship, James B.  
Bonner, Mark  
Box, Ivan H.  
Boyce, John M.  
Brooks, D. Wayne  
Brooks, W. Ely  
Brown, Craig  
Brown, David L.  
Brunner, John A. III  
Burnside, Wade W. Jr.  
Burton, Anthony R.  
Butler, G. Harrison  
Carver, Joel D.  
Chase, Patrick R.  
Cherry, James F.  
Churchill, David  
Clouatre, Michael Paul  
Coker, Tom Patrick  
Cole, George R. Jr.  
Cooper, Craig  
Councille, Clifford C. Jr.  
Crittenden, David R.  
Crocker, Thermon R.  
Cross, Michael J.  
Cunningham, Darrin D.  
Danks, Kelly R.  
Davis, David A.  
Davis, Randall  
Decker, Harold  
Deen, Lewis S.  
Dodson, C. Dwight  
Duke, David D.

Duncan, Philip E.  
Dykman, Thomas R.  
Eck, Gareth  
Embry, Travis D.  
Endsley, Charolette  
Ferguson, Susan Portis  
Fincher, G. Glen  
Fink, Roger Lee II  
Fish, Ted J.  
Fossey, Carol  
Gardner, Buford M. #  
Garibaldi, Byron T.  
Garner, Hershel H.  
Ginger, John D.  
Gray, Dalton L. II  
Grear, Danna  
Green, Michael D.  
Grote, Walton  
Gyles, Nicholas R. II  
Haisten, James  
Hall, Ben  
Hall, Joe B.  
Hamilton, Herbert E.  
Harris, David Jay  
Harris, Murray  
Harris, Paul L.  
Harris, W. Duke  
Harrison, William F.  
Hart, Hamilton R.  
Hayward, Malcolm L. Jr.  
Hedberg, Curtis  
Heinzelmann, Peter R.  
Hendrycy, Paul R.  
Henry, Morris M.  
Henry, Paul M.  
Higginbotham, Hugh B.  
Higginbotham, William  
Hollomon, Michael  
Hui, Anthony  
Hurlbut, Kevin  
Hutson, Martha  
Hutson, Sanford E. III  
Inlow, Charles W.  
Jaderborg, Jana M.  
Jay, Gilbert D. III  
Johnson, Brad D.  
Johnson, Miles M.  
Knox, D. Luke  
Koehn, Laura J.  
Kraichoke, Saran  
Kyle, Richard  
Lloyd, Richard A.  
Loftin, Teresa D.  
Magness, C. R.  
Martin, F. Allan  
Martin, William C.  
Mashburn, James D.  
McAlister, Joseph H.  
McAlister, Mitchell  
McBee, Sara  
McDonald, James E. II  
McElroy, Kellye

McEvoy, Francis  
McGhee, Linda M.  
McGowan, William  
McNair, William R.  
Miller, Charles H.  
Miller, Mark E.  
Mills, William C. III  
Mitchell, Banford R. Jr.  
Moon, Steven L.  
Moore, James F.  
Moose, John I.  
Morse, Michael  
Mullis, R. Jay  
Murry, J. Warren  
Nettleship, Mae B.  
Nowlin, William B.  
Ortego, Terryl J.  
Pang, Robert R.  
Parashara, Deepak K.  
Park, John P.  
Parker, Lee B. Jr.  
Patrick, James K.  
Pearson, Fran  
Pichoff, Bruce Edward  
Pickett, James D.  
Pickhardt, Mark G.  
Pope, Kevin L.  
Powell, Mark W.  
Power, John R.  
Proffitt, Danny L.  
Raben, C. A. Tony  
Riddick, Earl B. Jr.  
Riner, Dan M.  
Rogerson, Susan H.  
Romine, James C.  
Rosenzweig, Kenneth  
Ross, Joseph  
Rouse, Joe P.  
Runnels, Vincent B.  
Saitta, Michael R.  
Salvador, Ester Arejola  
Sandefur, Barbara A.  
Sanders, Scott  
Sandler, Richard  
Schemel, Lawrence J.  
Schmidt, Clinton C.  
Sexton, Giles A.  
Sexton, Jon A.  
Shaddox, T. Stephen  
Sharkey, Martha Ann  
Sharp, Jim D.  
Siegel, Lawrence H. #  
Simmons, Thomas  
Simpson, Todd R.  
Singleton, E. Mitchell  
Sisco, Charles P.  
Smith, Austin C.  
Snyder, Norman I.  
St.Clair, Kevin  
Stagg, Stephen W.  
Taylor, Robert G.  
Tellez, Guillermo J.

Thomas, Gary A.  
Thomas, Joanna M.  
Thorn, Garland M. Jr.  
Titus, Janet L.  
Tuttle, Larry D.  
Ureckis, David  
Weed, Wendell W.  
Weiss, John B.  
Wheat, Ed Jr.  
Whiteley, Andre  
Whiting, Tom D.  
Williams, John R.  
Wood, Jack A.  
Wood, Russell Hunter  
Wood, Stephen T.

### White County

Asmar, Salomon  
Baker, Ronald L.  
Ballinger, Phillip Scott  
Bell, John  
Blakely, Brent M.  
Blickenstaff, Kyle R.  
Blue, Glen T.  
Blue, Leon R.  
Brown, Arnold R.  
Brown, Mark A.  
Brown, Peggy J.  
Brown, Terry Mac  
Burns, Jerry  
Citty, Jim C.  
Collier, Steven F.  
Covey, David C.  
Davidson, Daniel  
Dicus, G. Scott  
Dugger, Joseph S.  
Elliott, Robert E.  
Fincher, S. Clark  
Formby, Thomas A.  
Gardner, Jack R.  
Gibbs, William M. III  
Golleher, James H.  
Hannah, J. Todd  
Hatfield, David L.  
Henderson, John C.  
Holston, John S.  
Jackson, Clarence W.  
Johnson, David M.  
Joseph, Eugene A.  
Justus, Michael G.  
Killough, Larry R.  
Kinley, J. Garrett  
Koch, Clarence W. Jr.  
Lefler, Stephen F.  
Lewing, Hugh S.  
Lewis, James Sheridan  
Lowery, Benjamin R.  
Lowery, Robert D.  
McAdams, Edward L.  
McCoy, James R.  
Meacham, Kenneth R.  
Moore, Donald



Moore, Jesse  
 Muirhead, Michael J.  
 Nevins, William H.  
 Norris, E. Lloyd  
 Payne, Cheryl  
 Ramirez, Raul  
 Ransom, C. E. Jr.  
 Riddick, Robert S.  
 Risinger, Melanie W.  
 Robertson, William T.  
 Rodgers, Porter R. Jr.  
 Sanchez-Montserrat, Rafael  
 Schwartz, Stanley S.  
 Shultz, Sam L.  
 Simpson, James A.  
 Smith, Bernard C.  
 Smith, Bob W.  
 Spence, Don K.  
 Staggs, David L.  
 Stinnett, J. L.  
 Tate, Sidney W.  
 Thompson, Bruce  
 Weathers, Larry W.  
 White, Bradley  
 White, William M.  
 Williams, W. Curtis  
 Yates, Terrence  
 Young, Jack S. III

#### Woodruff County

Hendrixson, Basil E.  
 Rowe, James E.

#### Yell County

Banning, Michelle Shelly  
 Green, Terry G.  
 Hodges, Jerry F.  
 Isely, William A. Jr.  
 Martin, Damon G. H.  
 Maupin, James L.  
 Pennington, James O.  
 Ring, Gene D.  
 Russell, Gary W.  
 Scott, William P.  
 Tippin, Philip

#### Direct Member

Abdulrauf, Saleem I.  
 Aboul-Magd, Ahmed S.  
 Akkad, Nabil  
 Albin, Amy Wilson  
 Alexiou, Jerri  
 Alfano, Thomas G.  
 Allard, Mark  
 Anderson, Patric Neil  
 Anderson, Roger Wilbert  
 Andreoli, Thomas E.  
 Andrews, Nancy R.  
 Angtuaco, Sylvia S.O.  
 Antakli, Tamim  
 Araneda, Erick R.  
 Athurguthu, Jithendra Mohan

Bacon, Lori  
 Baker, Karen  
 Banaji, Sudesh  
 Barone, Gary  
 Barrett, Rebecca  
 Baxley, Paul J.  
 Beebe, William E.  
 Beeman, David  
 Benafield, Robert B.  
 Bingham, Jennifer A.  
 Blackstock, Terri  
 Blaszak, Richard T.  
 Bonwich, Janina B.  
 Bowman, Raymond N.  
 Brodsky, Michael  
 Brooks, Homer E. III  
 Brown, Richard E. Jr.  
 Brown, Robert D.  
 Brull, Sorin J.  
 Burns, Stanley  
 Bushman, Gerald A.  
 Camp, Michael  
 Campbell, James A. Jr.  
 Cannon, R. David  
 Cardenas, Jaime A.  
 Carey, Martin John  
 Carey, Victor Jr.  
 Carroll, Barry  
 Carter, Inge Renate  
 Cash, J. Steven  
 Cashion, Ernest Lowery  
 Cerrato, Deborah  
 Chan, Kenneth  
 Chandler, Rodney  
 Cheek, William Clark #  
 Cheney, Lori M.  
 Chitwood, G. Glen  
 Chu, Tommy D.  
 Clark, Teresa  
 Claycomb, Scott C.  
 Cohagan, Donald L.  
 Coke, Courtney C.  
 Coker, Tom P.  
 Collins, John O.  
 Cook, Joseph A.  
 Counce, James S.  
 Cox, Judd G.  
 Daidone, Paul E.  
 Day, David W.  
 De Miranda, Federico Carlos  
 DeSoto, David J.  
 Dinehart, Scott  
 Dmowski, Andrzej T.  
 Dolak, James A.  
 Duke, J. Richard  
 Dunigan, Rodger  
 Dunn, Laura  
 Eaton-Wilmoth, Rayettea L.  
 Ebel, Susan  
 Economides, Nicholas  
 Edattukaren, Varghese  
 Edwards, Peter M.

Ekanem, Felix  
 Ellis, Margaret P.  
 Emery, Robert  
 Farajallah, Awny  
 Farst, Karen J.  
 Feiz, Vahid  
 Ferrer, Thomas J.  
 Fiser, Debra H.  
 Flanigin, Richard  
 Florendo, Noel  
 Freeman, Jerre M.  
 Freeman, William H.  
 Frigon, Gary F.  
 Gardial, J. Richard  
 Gensler, Thomas D.  
 Gilbert, Jimmy  
 Gober, Gregg  
 Goodman, Jack  
 Goodson, Timothy C.  
 Gordon, Alfred Y. Jr.  
 Gordon, Gayle  
 Graham, Charles J.  
 Greene, Graham F.  
 Gregory, Jo Anne  
 Griffin, Frankie M.  
 Grisham, Dannetta  
 Gungor, Anil  
 Guyer, Janet  
 Haas, David C.  
 Haran, Panchapakesan P.  
 Hardin, A. Scott  
 Hardy, Kyle G.  
 Harik, Sami I.  
 Harper, Richard  
 Harrell, Robert E. Jr.  
 Harris, Russell  
 Harris, Shirley D.  
 Hass, Farrell D.  
 Heard, Jeanne K.  
 Henry-Tillman, Ronda S.  
 Hester, Wes  
 Hilman, Michael G.  
 Himmelstein, Stevan I.  
 Hodges, John M.  
 Holloway, David H. Jr.  
 Hudson, Amy R.  
 Hughes, Alan W.  
 Hughes, Laurie O.  
 Hurwitz, Mervyn B.  
 Huynh, Chanh V.  
 Ibrahim, Hossam  
 Imamura, Bryan  
 Istanbuli, Wajih  
 Izard, Ralph S. Jr.  
 Jabbour, J. T.  
 Jackson, Charles A.  
 Jasin, Hugo  
 Jewell, Shannon  
 Jimenez, Jorge F.  
 Johnson, Sandra  
 Johnston, Greg  
 Jones, Robert E.

Joseph, Jacob  
 Kale, Robert  
 Kazakevicius, Rimantas  
 Kempson, Steven E.  
 Kendrick, Carl M.  
 Khan, Ahmed  
 King, William R.  
 Kinney, Joyce  
 Kirchner, Jeffrey  
 Kirchner, JoAnn  
 Kiss, Csaba  
 Kluck, Carl Jr.  
 Knowles, Glen C.  
 Koenig, A. Samuel III  
 Krempp, Richard E.  
 Krisht, Ali F.  
 Laffoon, Gregory  
 Lamps, Christopher A.  
 Lane, Joel Robin  
 Lang, Patricia A.  
 Lawrence, Debra C.  
 Lazenby, John  
 LeBoeuf, Dorothy  
 Lewellen, Thomas Lynn Sr.  
 Lewis, Charles  
 Linskey, Mark Elwood  
 Lipsmeyer, Eleanor  
 Lister, Danny  
 Little, J. Aaron  
 Lorenzo, Edilberto B.  
 Lowery, Lisa  
 Lyle, Robert  
 Lynch, Paula  
 Mallare, Johanna  
 Marotti, Tonya L.  
 Marshall, Glenn E.  
 Maxwell, Teresa  
 Mayhew, Kathy  
 McAndrew, Brian P.  
 McKenzie, James  
 McMicheal, Wanda V.  
 Meador, A. Sharon  
 Miller, Laurence H.  
 Moffett, Shirolyn R.  
 Moin, Khurram  
 Moutos, Dean M.  
 Murry, William L.  
 Nader, Nader D.  
 Nadvi, Samina Zareen  
 Nelson, Richard A.  
 Newcomb, T.L.  
 Newton, J. Camp  
 Nichols, Scott  
 Osofisan, Olaniyi  
 Paine, Johnny R.  
 Pait, Thomas Glenn  
 Papageorge, Dean  
 Pappas, Lila  
 Pappas, Paul H.  
 Parchman, A. Janette  
 Parker, A. Wade  
 Partridge, Paige M.

Paulson, Kathleen  
 Perkins, Lalita  
 Phillips, David Lance  
 Phomakay, Von  
 Ploetz, Carina  
 Plunk, Hermie G.  
 Porterfield, James G.  
 Powers, Robert  
 Prince, Audra M.  
 Purnell, Gary L.  
 Rasberry, Ronnie D.  
 Reddy, Krishna  
 Reid, Graham M.  
 Robertson, John A.  
 Robinson, Martin J.  
 Robinson, Nancy  
 Rodgers, Kenneth  
 Rodkin, Richard S.  
 Rodriguez, Johnny R.  
 Rodriguez, Linda M.  
 Rowe, Tracy L.  
 Rucker, Gari  
 Rumans, Todd M.  
 Sakr, Safwan  
 Samman, Zaki A.  
 Saucedo, Jorge F.  
 Schexnayder, Stephen M.  
 Schmidt, David  
 Seib, Paul M.  
 Shah, Rajesh V.  
 Shapira, Iuliana T.  
 Shaver, Robert  
 Sheikha, Mouhammed K.  
 Sherman, Alan W.  
 Short, Luke H.  
 Sites, Terry Jay  
 Slezak, James  
 Smith, Carl  
 Smith, Eugene III  
 Smith, Kirby L.  
 Snow, Sandra L.  
 Speed, Darrell  
 Standefer, J. Michael  
 Starnes, C. Wayne  
 Steely, Donald  
 Stern, Thomas N.  
 Stewart, David L.  
 Sturner, William Q.  
 Sullivan, Sarah L.  
 Sweeney, Lynn  
 Tait, Amy  
 Tait, Layne  
 Talley, J. David  
 Tanner, Paul R.  
 Teal, Linda  
 Thomas, Jonathan  
 Thompson, Jerome W.  
 Thompson, Robert C.  
 Thomsen Hall, Kathleen #  
 Tollett, Michael Hines  
 Tutt, Richard D.  
 Tutton, James

Van Hemert, Rudy  
 Veach, Paul A.  
 Vermont, Charles  
 Waheed, Atiya N.  
 Waldron, James A. Jr.  
 Walker, Brent  
 Waller, John  
 Ward, Joseph P.  
 Warmack, Asa M.  
 Webb, John W.  
 Westwood, John Jr.  
 Wharton, James R.  
 Wheeler, Richard  
 White, Faber A. Jr.  
 Williams, Chrysti  
 Williams, Debra  
 Williams, Nancy K.  
 Williams, Sonia T.  
 Willis, Charlotte  
 Wilson, Matthew  
 Wilson, Robert B. Jr.  
 Wilson, Steven K.  
 Wood, Michael D.  
 Wren, Mark  
 Yawn, Timothy  
 Yetman, Anji T.  
 Yoltar, Rukiye  
 Young, Jeffrey P.  
 Young, Michael C.  
 Young, Sandra S.  
 Yuen, James C.  
 Yunus, Nauman  
 Zelk, Misty M.  
 Zini, James E.

### Students

Abdin, Jamal  
 Acott, Alison A.  
 Afsordeh, Nirvana  
 Ahrens, Mitchell A.  
 Akbar, Safdar Ali  
 Akins, John P.  
 Alexander, Jan  
 Ancalmo, Claudia M.  
 Arthur, David E.  
 Ashbrooks, Darrin D.  
 Athota, Anupama B.  
 Baggett, Stephanie  
 Bailey, Amy E.  
 Baker, Ashley  
 Baker, Robbie C.  
 Baker, Todd F.  
 Baltz, Alexander J.  
 Barden, Michael G.  
 Bariola, Jeremy R.  
 Barker, Lisa R.  
 Barr, Susan  
 Beard, Jessica L.  
 Beck, David  
 Beck, Jason D.  
 Bell, Tanya R.  
 Bell, Todd E.

Bess, Barbara  
 Bhattacharyya, Debasish  
 Bibb, Brad  
 Bibbs, David L.  
 Bierbaum, Anna C.  
 Bierbaum, Walter F.  
 Bishop, Michelle  
 Blanchard, Mary  
 Bledsoe, Samuel E.  
 Bohra, Robin I.  
 Boling, Carrie T.  
 Booth, Billynda L.  
 Borg, Clayton D.  
 Bowman, Vernon D.  
 Bracy, Brian  
 Bradshaw, Mark  
 Brannick, James M.  
 Brashears, Reta  
 Braswell, Leah E.  
 Brewer, Jim E.  
 Brown, David P.  
 Brown, Donna  
 Brown, Scott P.  
 Bryant, Gwendolyn M.  
 Bryant, Shelly L.  
 Bufford, Jeremy D.  
 Burris, Cara B.  
 Campbell, Jenny  
 Campbell, Lucas K.  
 Campbell, Rachel C.  
 Carlton, Caroline F.  
 Carozza, Michael C.  
 Carrouth, David  
 Carter, Sherri R.  
 Casey, Sean P.  
 Cash, Jodi L.  
 Cassat, James E.  
 Causbie, Jessica  
 Cawich, Ian  
 Cawyer, John C.  
 Chalfant, Paul  
 Chi, Jasen C.  
 Chism, Brandon  
 Citty, James K.  
 Clingan, Warren  
 Cobb, William C.  
 Cogbill, James M. Jr.  
 Coleman, Brendan  
 Collins, Sidney W. Jr.  
 Cook, Michael  
 Cordell, Cari L.  
 Cordon, Krista J.  
 Counts, Brian W.  
 Covert, Kent  
 Cox, Wesley  
 Craig, Jennifer  
 Crider, Stacy L.  
 Criner, Owen K.  
 Croker, Mary Ellen  
 Cupples, Laura E.  
 DaVeiga, Adriana  
 Daily, Jason G.

Daniel, Andrew D.  
 Dannaway, Douglas C.  
 Dannull, Kimberly A.  
 Dare, Jason A.  
 Darwin, Amy L.  
 Daugherty, Jeremy  
 Davidson, April  
 Davidson, Gretchen M.  
 Davis, James O.  
 Davis, Jeremy C.  
 DeWitt, Keitha R.  
 Denton, Meredith  
 Depko, Joshua M.  
 Dickinson, Jacob  
 Diemer, Heather M.  
 Dill, Kenneth  
 Dolbeare, Dirk W.  
 Dopkou, Joshua  
 Dorman, Robert B.  
 Dougan, Jason O.  
 Downen, Brian  
 Drobeno, Gina A.  
 Duffy, Laura  
 Dunlap, Melinda S.  
 Dunn, Jeremy  
 Dwyer, R. Gregg  
 Dye, Daniel  
 Dyer, Mark A.  
 Earl, K. Sam  
 Easley, Seth  
 Ebarb, Jeanette M.  
 Ekechukwu, Martina C.  
 Ellis, Michael  
 Engle, David B.  
 Ennis, Jared S.  
 Enns, Michael W.  
 Evans, Clinton E.  
 Evans, Melia  
 Faddis, Lance A.  
 Fagen, Bryan C.  
 Fallon, Amy M.  
 Fisher, Andrew M.  
 Fitzgerald, Ryan T.  
 Fletcher, Brent F.  
 Fletcher, Terry  
 Flowers, Rebekah  
 Fong, Shirley  
 Fore, Daniel B.  
 Forrest, Robert P.  
 Fox, Patrick J.  
 Fraley, Patrick L.  
 France, Erica H.  
 Frederick, John T.  
 Freeland, Michael B.  
 Frego, Jonathan L.  
 Gathright, Kenneth  
 George, Matthew S.  
 Geren, Blake  
 Glasgow, Meriden A.  
 Glass, Melanie D.  
 Glover, Forrest D.  
 Go, Jean K.



Golden, Carmen N.	Johnson, Dwight J.	Lyle, C. Wayne	Owen, Marcus A.
Goodman, Brian	Johnson, Jeff W.	Madden, Mac Jr.	Owens, Daniel J.
Goodwin, Whitney J.	Johnson, Kelly C.	Maner, Jamie	Padilla, Kricia D.
Goosby, Nova D.	Jones, Bridgette L.	Manning, Thomas A. III	Pafford, Michael B.
Gordin, Audrey L.	Jones, David G.	Manry, James A.	Pai, Vinaya B.
Gordon, Eric H.	Jones, Sherri	Markey, Janell M.	Paladino, Johnathan D.
Graham, Charles G.	Jones, Steven S.	Martin, Cade	Palmer, Jonathon D.
Graham, Jeffrey B.	Jones, William S.	Mashek, Charles C.	Palmer, Kricia P.
Gray, Rickey C.	Jordan, Barry	Mason, William	Palmer, Lolita V.
Green, Edward D.	Joshua, Jabbar A.	McAnulty, Brent C.	Palmer, William J.
Gupta, Ramona	Jumper, Zachary	McBain, Stacy	Palmer, William S.
Gustafson, Craig A.	Kaakaji, Rami	McCallum, Sanford B.	Panek, Ralph C.
Hair, Kelly C.	Kaufman, Melissa R.	McCarley, James R.	Pardue, Michelle L.
Hall, Annette N.	Keels, Tansyla D.	McCarty, Christopher	Park, Jong C.
Halter, Steven J.	Kelley, Morris	McCarver, Rodney H.	Park, Jong S.
Haltom, John	Kelly, Derek	McCaie, Theresa	Parker, Jonathan M.
Hardin, Laura A.	Kemp, Susan A.	McCoy, Justin L.	Parnell, Amy Carol
Harjan, Harjot S.	Kendall, William B.	McFarlane, Adrienne C.	Patel, Nimesh
Harris, Bryson C.	Khan, Adnan	McGarity, Timothy	Patterson, Deric W.
Harrison-Lightburn, Marla K.	Khan, Amir S.	McGaugh, Janette	Paul, Eric M.
Haustein, Matthews	Kim, Charles	McGeorge, Susan M.	Payne, Michael D.
Hawkins, William L.	Kim, Peter J.	McGowen, Philip H.	Peldun, Renee G.
Hayes, William J.	Kincade, Matthew	McGrimley, Laura M.	Pennington, Jaymie H.
Haynes, Katherine L.	King, Kristy S.	McKelvey, Samantha S.	Perick, Ted M.
Heinzelmann, Andrew D.	Kirby, Deborah	McMasters, Mark A.	Perrin, Shelly
Hellmer, Thomas R.	Kit, Brian K.	McNew, Gina L.	Pesek, Robbie D.
Hendren, Ryan L.	Kleinbeck, Seth M.	McVay, Marcene R.	Phan, Dan C.
Hendrickson, Blair L.	Klutts, James	Meads, Anthony	Phelps, Dawn
Henriksen, John	Knott, Kyle	Menendez, Chris A.	Phillips, Amanda R.
Henry, Lance B.	Koffler, Molly	Merryman, Daron E.	Pierce, Barry D.
Herrin, Kathy J.	Krenn, Louis P.	Middleton, Jennifer L.	Pillow, Gill G.
Hinton, Jeremy	Kueter, Daniel B.	Middleton, Owen L.	Pittman, Christopher
Hinton, Richard W.	Kuykendall, Tracy	Milam, Sarah	Pittman, Shannon
Hoang, Thuy T.	LaGuardia, Stephen	Miles, Caroline S.	Pleasants, Elizabeth
Hodges, Anissa	LaRue, Oakley	Molden, Raymond K.	Polkowski, Gregory G. II
Hogan, W. McCall Jr.	Lai, Michelle	Montgomery, Matthew	Poon, Kenneth Y.
Holden, James R.	Lam, David	Mooberry, Micah J.	Pope, Mark
Holder, Kasey M.	Lamkin, Anthony W.	Mooney, Brian W.	Porchia, Sylvia
Holt, Jason L.	Lavender, Kristopher	Moore, Amy	Powers, Cara
Hooper, Matthew C.	Lawrence, Kevin	Moore, Arthura D.	Price, Joanne
Hopkins, Sarah E.	Lawson, Nicole M.	Moore, John D.	Pritchard, Charles
Howard, Don N.	Le, Vu	Moore, Pittman D.	Provost, Scott L.
Hughes, Angela	Leach, Pamela	Moran, Scott	Qualls-Statler, Kristi L.
Hughes, Bradley R.	Lebeda, Ray	Morgan, Derek L.	Qureshi, Irfan
Hunt, James	Lee, Jonathan	Morgan, James	Rabjohn, Pat A.
Hunt, Justin	Leslie, John T.	Moseley, Tommy H.	Ragland, James
Huntley, Andrea L.	Lester, Robert	Moss, Allison	Rankin, Joshua D.
Hurt, Jason W.	Lewis, Johnathan W.	Moss, Mark	Ransom, Michelle M.
Hussain, Elora	Lewis, Steven R.	Mull, Kawonia	Raper, Thomas B.
Hussain, Tanvir	Lindsey, Marla E.	Murphy, Brandon D.	Rapp, Jennifer A.
Hutton, Theron	Linn, Brian K.	Nazaruk, Rachel Ann	Rashweed, Kashaf
Hyatt, Bryan T.	Linsky, Russell A.	Nelson, Joseph P.	Reeves, Charles Jr.
Ison, Keith A.	Lipke, Lindsay A.	Nelson, Tyler	Reynolds, James J.
Jackman, Kimberly M.	Lipsmeyer, Christopher P.	Nicholas, Kremer B.	Richmond, David A.
Jacobs, Kelly A.	Loe, Shanan M.	Nix, Matthew	Rippy, Kelli L.
Jansen, Joe	Lofton, Jason D.	Nunez, Rebekah	Robert, Stephen M.
Jansen, Stephen	Lombeida, Heather	O'Bryan, Gerald K.	Roberts, Gregory J.
Janson, Brian J.	Lombeida, Juan	O'Neal, Heather	Robertson, Sarah E.
Jarrard, Kristin A.	Lou, Angela	Oge', Brian T.	Robinson, Eric
Jauss, Kewen	Love, Monica	Osborn, Matthew B.	Ross, Jonathan H.
Jensen, Beth A.	Lovelace, Kimberly	Owen, Anthony	Royster, Eric
Johnson, David G.	Luistro, Anthony	Owen, Justin L.	Russell, James L.

Russell, Sheri L.  
 Rutledge, Estelle A.  
 Sanders, Jarret D.  
 Sanford, Garrett  
 Sarver, Matthew R.  
 Schlegel, Kelly  
 Schluferman, Christopher A.  
 Schmucker, Tracey A.  
 Schneider, Elizabeth A.  
 Schriver, Byron L.  
 Scifres, Whitney J.  
 Scrape, Scott R.  
 Seale, Jared J.  
 Seibert, John W.  
 Self, Matthew  
 Sellers, Matthew A.  
 Seme, Melissa D.  
 Seribner, John  
 Shah, Neilesh Kumar  
 Shanlever, Suzanne J.  
 Shannon, Melissa L.  
 Shelton, Jeffrey W.  
 Shipman, Grover  
 Showalter, Heath  
 Shrum, Matthew M.  
 Shultz, Erik P.  
 Sills, Adam A.  
 Silvey, Brentley  
 Sloan, Anthony B.  
 Sloan, Valerie A.  
 Smith, Jason  
 Smith, Jevin A.  
 Smith, Marcus  
 Smith, Philip  
 Spann, David C.  
 Sparks, Matthew A.  
 Spencer, Clay R.  
 Stacey, David H.  
 Staggs, Brent C.  
 Stallcup, Jim W.  
 Starnes, Harrison B.  
 Statler, Kristi Q.  
 Steed, Matthew G.  
 Stennett, Melissa D.  
 Stephens, Greg  
 Stevens, Charles  
 Stewart, Brent T.  
 Stewart, Eric J.  
 Stewart, Garry  
 Stewart, Tami W.  
 Storm, Elizabeth A.  
 Strnad, Petra  
 Stroud, Michael H.  
 Sublett, Jack D. II  
 Surati, Millie J.  
 Svoboda, Robert P.  
 Swift, Shannon S.  
 Swymn, Jeremy  
 Ta, Huong J.  
 Talbert, Lisa  
 Tarini, Gregg L.  
 Tate, Wesley A.

Taylor, John  
 Tharp, Shane  
 Theilken, Luke S.  
 Theus, John W.  
 Thies, Joseph B.  
 Thomas, Brad A.  
 Thomas, Martha  
 Thompson, Bobby  
 Thompson, John W.  
 Thompson, P. Keith  
 Thomsen, Isaac P.  
 Tilley, Spencer B.  
 Totten, Matthew B.  
 Treece, Brannon  
 Turney, Nathan W.  
 Tyler, David E.  
 Tyler-Hashemi, Alexander A.  
 Unger, Adriana M.  
 Vancil, Tobias J.  
 Vanderburg, Edward  
 Vester, Sara E.  
 Vickery, Jason E.  
 Vogler, Carolyn E.  
 Vyas, Keyur S.  
 Wagner, Michael D.  
 Wagner, Tommy W.  
 Walker, Christy W.  
 Walker, Torrance A.  
 Wallace, Aaron  
 Wallace, Bradley A.  
 Walsh, Donald  
 Wang-Gillam, Andrea  
 Ward, Aaron R.  
 Ward, Leslie D.  
 Warford, Jeremy A.  
 Warriner, Amy H.  
 Wassell, David L.  
 Wayne, Brian  
 Webb, Christopher  
 Webb, Jonna  
 Wells, Robert  
 Welter, Kimberly R.  
 Wenger, Alyssa N.  
 Weyenberg, Matt G.  
 Whaley, Kevin D.  
 White, Faber A.  
 White, Jonathan D.  
 White, Justin S.  
 White, Michael  
 Whitlock, Shane  
 Wilbert-Starks, Tasha  
 Williams, Melissa B.  
 Williams, Misty Leigh  
 Williams, Rhonda J.  
 Williams, Sharenda L.  
 Willis, Sherita D.  
 Winkley, Rachel  
 Wirges, Richard S.  
 Wise, Jeremy  
 Wise, Marc E.  
 Witherington, Brent V.  
 Wood, Melissa

Woodruff, Anthony J.  
 Woods, B. Gennice  
 Wooley, Katherine D.  
 Wright, Lonnie B.  
 Wu, Michael C.  
 Wyrick, Theresa  
 Yarnell, Bryan  
 Yawn, Melissa M.  
 Young, Erik J.  
 Zawada, Gregory  
 Zwiesler, Daniel J.

### Residents

Adams, Laura L.  
 Adler, Ira  
 Aguinaga, Miguel  
 Ahart, Cheryl L.  
 Ahmad, Ibrahim  
 Aidoo-Akama-Makia,  
 Jennifer A. #  
 Al-Nashif, Ali  
 Al-Takroui, Hatem A.  
 Alam, Muhammad G.  
 Albanna, Ahmed Q.S.  
 Albertson, Christopher M.  
 Alberty, Bernadette A.  
 Alexiou, Michael A.  
 Allen, Julia  
 Anthony, Angela  
 Appelgren, Rebecca  
 Arendall, Clarence J.  
 Arick, Carmen L.  
 Arnautovic, Kenan I.  
 Arnold, James R.  
 Arora, Harendra  
 Arthur, Lee E.  
 Atreides, Sean-Paul  
 Bacchus, Amy C.  
 Bailey, W. Brian  
 Bakhtawar, Iram  
 Ball, Peter H.  
 Ballard, Devon R.  
 Baltz, Tracy C.  
 Barboza, Jodi M.  
 Barkai, Alex  
 Baselious, Joseph  
 Bayer-Garner, Ilene Bertha  
 Belk, James  
 Belk, Robert J.  
 Belue, Kara D.  
 Bennett, Leigh A.  
 Benton, Thomas H.  
 Berestnev, Konstantin V.  
 Bertrand, Skipper J.  
 Bhutta, Adnan T.  
 Bhutta, Sadaf  
 Blair, Brian H.  
 Bland, Marnie  
 Blankers, Christian G.  
 Bledsoe, Gregory  
 Boger, Eve H.  
 Boger, William G.  
 Boone, Ryan  
 Borisova, Irina  
 Braswell, Camille S.  
 Brock, Wade D.  
 Brown, Columbus  
 Brown, Daniel K.  
 Brown, Keith  
 Brownfield, Shannon H.  
 Bryant, Christopher S.  
 Buffalo, Ryan P.  
 Bullard, Michelle  
 Burke, Richard A.  
 Burks, Jennifer E.  
 Butler, Kathleen V.  
 Cadle, Kimberly  
 Cannon, Thomas C.  
 Carlton, Randall  
 Cash, David  
 Cash, Paige P.  
 Cathey, James D.  
 Cavaneau, Nick  
 Ceola, Ashley  
 Ceola, Wade  
 Chadha, Mandeep S.  
 Chatoth, Dinesh K.  
 Chavis, Brent D.  
 Cheema, Puneet  
 Chen, Jing X.  
 Chen, Xiaoling  
 Chiles, Melissa  
 Chiles, Walter III  
 Chumley, Willard T. Jr.  
 Clardy, Bryan H.  
 Cobb, J. Christopher  
 Cockrum, Holly D.  
 Cody, Stephanie G.  
 Cogbill, Kay L.  
 Coker, Raymond K.  
 Cole, Richard W.  
 Collier, Jack  
 Collier, Susannah  
 Collins, Gwynetta M.  
 Collins, Vera Y.  
 Cooper, Kara  
 Coppola, Angelo Jr.  
 Corbell, Mark E.  
 Cotner, James B.  
 Cowherd, Kristy  
 Cowherd, Robert M.  
 Crisp, Constance J.  
 Daniel, Jamie  
 Danner, Christopher  
 Dansby, Jason  
 Davis, John C.  
 Davis, Jonathan  
 Davis, Richard K. Jr.  
 Dawson, Justin D.  
 Day, Jeffrey L.  
 de Saint-Felix, Douglas  
 DeNeen, Andrea' E.  
 Denson, Alyson  
 Devarajan, Sumathi



Dickson, Brian G.	Harik, Nada	Kumar, Priya	Myers, Michael
Dickson, Scott M.	Harlan, Brian	Kyasa, Mouhammed	Nelson, Elizabeth B.
Diles, Timothy R.	Harms, Sally S.	Kyser, Steven M.	Nelson, James C. Jr.
Dillaha, Jennifer	Harris, Daniel	Lassieur, Susanne M.	Netherland, Clinton
Dominguez-Ventura, Alberto	Harris, Julie A.	Latch, Rebecca L.	Nguyen, Larry
Dvoryansky, Andrew	Hart, Michael	Layton, Ann D.	Nguyen, Xuan-Mai T.
Eads, Lou Ann	Hartman, Arthur R.	Leatherman, Bryan D.	Noel, Stacey W.
Easom, Delilah L.	Harton, Scott	LeDay, Romona	Nolen, John R.
Eble, Brian	Harvey, Shelly M.	Lee, Ronnie D.	Nolen, Michael
Eckles, Laura W.	Hays, Deborah A.	Lehmkuhl, Rachel J.	Norris, Brian B.
Elliott, Jana	Heif, Muhannad M.	Lewis, Barrett D.	Northrop, Robert C.
Elnabity, Mohamed	Helsel, Jay C.	Lian, Fangru	Nowell, Becky A.
England, Lane G.	Herring, John	Lightfoot, Meredith L.	O'Connell, Joseph
Ensminger, Bobby T.	Higgins, Rhonda Edison	Lochala, Roddy	Onglao, Ana M.
Escarda, Joe O.	Hillis, Thomas M.	Long, Eric D.	Orgler, Raymond Jr.
Fahr, Michael	Holland, Cheryl	Long, Michael J.	Overholt, Shelley
Faith, Jennifer J.	Hollis, Thomas H. Jr.	Lu, Ellen	Owens, R. Brian
Fant, Jerri S.	Holmes, David G.	Luelf, Claire J.	Ozdemir, Aytekin
Farmer, Kimberly J.	Holmes, RonaBeth R.	Luper, Rebecca	Ozment, Dennis W.
Feng, Zuliang	Holt, Brent E.	Lynn, W. Steve	Palvadi, Priti
Ferguson, Philip E.	Hoover, Melanie D.	Maddock, Thomas J.	Palvadi, Rajarama M.
Ferguson, Scott	Horan, Chris	Magre, Ann-Marie	Parker, Jason D.
Ferrill, Shelley C.	Hoskins, Gregory C.	Mahdavy, Mustafa	Parmar, Mona
Flaxman, Neesa Jill	Houston, Melinda L.	Major, Victoria E.	Parmley, Patricia E.
Fogata, Maria Luisa C.	Hudson, Stephen A.	Malik, Vipin	Pate, Kimball B.
Foley, Regina P.	Hutcheson, James	Manarang, Don V.	Patel, Harish
Fort, David Jr.	Irish, Katherine A.	Manavalan, Pius Louis	Patz, Brian
Foster, Jason	Jackson, Kevin T.	Mangat, Halinder	Paxton, Jason S.
Fox, Clinton W.	Jackson, Matthew P.	Markham, Larry	Payne, Elisa M.
Franks, Jason A.	Jackson, Phillip C.	Martin, Dawn	Peebles, Jody W.
Freyaldenhoven, Timothy E.	Jacobs, Robert	Martin, Kristi	Perrigin, Julie
Frino, John	James, William M.	Massoll, Nicole A.	Perry, Tamara L.
Furlow, John L.	Jarvis, Robert M.	Mathew, Sajini	Peterson, Hilary A.
Furlow, Stacy H.	Jayaprabhu, Sudheer M.	Mayfield, Jan	Peterson, Steve L.
Garcia, Robert	Jetton, Christina A.	McCall, Tyrone L.	Petty, Corwin D.
Gardner, Edward	Johnson, Brad R.	McClain, Charles M. III	Petursson, Lisa M.
Garlapati, Butchaiah	Johnson, Jennifer	McCourtney, Bill R. II	Phillips, Craig H.
Garrett-Shaver, Martha G.	Johnson, Larry "Jack" Jr.	McDonald, Rodney K.	Phillips, Kristina M.
Garrison, Robert L. II	Johnson, Michael W.	McDonnell, Bryan Dale	Phooshkooru, Vijay R.
Gaston, Caleb O.	Johnston, Alan C.	McDonnell, William M.	Pillow, James H.
Ghafoor, Abid	Jones, Chrystal D.	McGraw, Lisa K.	Pitas, Grzegorz A.
Gibbons, Glenn G.	Jones, Karla R.	McKee, John D.	Platt, Lucas Jr.
Gibson, Danielle C.	Kajitani, Michio	McKinney, Vanessa L.	Plumley, Spencer G. Jr.
Gibson, William D.	Karim, Aftab	McNellis, Emily M.	Pothuluri, Nomita J.
Goeke, Brad J.	Kazzar, Nelly Y.	McNellis, Ryan E.	Prada, Stefan Alexand
Grammer, W. Cody	Kellar, Jeffrey	McNiece, Karen L.	Price-Barnes, Shirley
Graves, Blane A.	Kellow, Amir L.	Meakin, Kevin David	Priest, Dean B. Jr.
Gray, Adam C.	Kelly, Owen L.	Merman, Rita	Pritchett, Daniel P.
Gray, David J.	Kern, Gordon	Merrick, Jason A.	Pyrone, Luke D.
Gray, Heather C.	Khassawneh, Basheer Yousuf	Moak, Candace	Queralt, Yvonne M.
Greenwood, David	Kidd, Joseph Jr.	Moix, Frank M. Jr.	Rajs-Nepomniashy, Roma
Gregory, J. Minor	Kinchen, Delaney L.	Molina, Diane K.	Ramiro, Mark
Griffin, Gary E.	Kinsey, Toyya	Montgomery, Christopher	Rankin, Jay
Guinn, Robby C.	Kligman, Svetlana	Moore, Heidi L.	Razmi, Syed Salman
Guinn, Spencer H.	Knox, Christopher G.	Moore, Troy G.	Reddy, Shankari S.
Gungor, Neslihan	Koehler, Kevin R.	Morgan, Christopher O.	Reynolds, Lisa S.
Gupta, Navneet	Kolb, David	Morgan, Justin E.	Rhodes, Robbie L.
Gwarnicki, Danuta	Konis, George	Morgan, Kelly J.	Riche, Andrew
Habibipour, Saied	Kota, Manjusha	Moss, Mark E.	Rickwartz, Kevin
Hadi, Ehsan M.	Ku, Tsun Sheng	Munir, Kavanaugh	Roach, Milton III
Handloser, Holly H.	Kubacak, Brian M.	Munir, Muhammad T.	Roberts, Russell Jr.
Hannon, Martin A.	Kueter, Joseph C.	Myers, Janette E.	Robertson, Jonathon C.

Rodgers, Chad T.  
 Rodgers, Michelle L.  
 Roe, Diana L.  
 Runion, Lance  
 Russ, Jennifer J.  
 Russell, Eric, B.  
 Sadler, Jennifer M.  
 Sadler, Philip K.  
 Sadziws, Laimis  
 Said, Sufyan  
 Samms, Donald  
 Samuel, Meshach V.  
 Sauer, Kenneth M.  
 Sayani, Namrata  
 Schad, Carla Jo  
 Schluterman, Keith O.  
 Schneider, Daniel L.  
 Schneider, Michael G.  
 Scoufos, Jennifer  
 Scurlock, Amy Martin  
 Scurlock, John P.  
 Sedaros, Robert S.  
 Shaffer, Kimberly K.  
 Shah, Shailesh R.  
 Shaw, Allison  
 Sheikholeslami, Mohammad  
 Shinde, Abhijit  
 Shipman Burton, Diana L.

Shoppach, Jon Paul  
 Short, Walter  
 Siddiqui, Sayyadul M.  
 Silas, David  
 Simmons, John P.  
 Skelley, Christopher  
 Skelley, Kimberly B.  
 Slabbert, Christiaan J.  
 Smith, Carol L.  
 Smith, LaNette  
 Smith, Todd P.  
 Sokan, Babatunde  
 Sotomayor, Edgar A.  
 Spradlin, Timothy L.  
 Sprinkle, Wesley  
 Srinivasan, Pattana  
 Staley, Kelly  
 Stamp, Jeffrey D.  
 Stark, Karen L.  
 Steeger, Jennifer A.  
 Stewart, Jason G.  
 Stovall, Stephanie H.  
 Strain, Lisa D.  
 Stuckey, Robert L.  
 Swarup, Sachin  
 Tarpley, Jon  
 Thomas, Debra J.  
 Thomas, Wesley C.

Tilley, James B.  
 Tillomans, Tad  
 Touijer, Abdelkrim  
 Tran, Viet N.  
 Triplett, Sheila B.  
 Tumison, Julie  
 Villamor, Shelaila  
 Vuppala, Aparna  
 Vuppala, Murthy S.  
 Wade, Kenneth  
 Waggoner, Bradley  
 Waheed, Imran  
 Walker, Randy  
 Wall, Chris D.  
 Walz, Brad H.  
 Ware, Gerald  
 Webber, John C.  
 Wells, Britton C.  
 West, Brian J.  
 West, Margaret  
 White, Aaron E.  
 Whiteside, Thomas F.  
 Wiedower, Amy C.  
 Williams, Mark C.  
 Williams, Tearani J.  
 Williams, Veronica  
 Williams, Victor  
 Wilson, Robert B. III

Winkler, J. Mitch  
 Wise, James N.  
 Wiseman, Merle D.  
 Woods, Jennifer L.  
 Woods, Mark A.  
 Wooten, R. Gregory  
 Workman, James L. Jr.  
 Wright, Kristen N.  
 Yeh, Y. Albert  
 York, Andrea  
 You, Jean  
 Zeng, Wenjia  
 Zhang, Yue Hong  
 Zimmerman, Stacy  
 Zufari, Hazem

## ADVERTISERS INDEX

AMS Benefits Inc. ....	Inside back cover
Arkansas Financial Group Inc., The .....	184
Arkansas Foundation for Medical Care .....	180
Asti, William Henry, AIA .....	185
Autoflex Leasing .....	179
Bradford Marine and ATV .....	199
Central Flying Service .....	197
Farmers Insurance Group .....	198
Fiser Hummer .....	184
Guesthouse Inn .....	199
Hoffman-Henry Insurance Corp. ....	197
Little Rock Medical Association .....	198
Maggio Law Firm .....	193
Mary Healey's Fine Jewelry .....	183
Metropolitan National Bank .....	183
PhyAmerica Physician Services Inc. ....	206
Professionals Advocate Insurance Co. ....	Inside front cover
Snell Prosthetic & Orthotic Laboratory .....	186
St. Vincent Health System .....	185
St. Paul Medical Services .....	204
State Volunteer Mutual Insurance Co. ....	Back cover

Special Publications  
 Publisher  
*Brigette Williams*

Special Publications  
 Editor-in-Chief  
*Natalie Gardner*

Assistant Editor  
*Christy L. Smith*

Copy Editor  
*Donna Schratz*

Sales Manager  
*Stephanie Hopkins*

Account Executives  
*Jason Carson*  
*Liz Earlywine*

Director of Design  
 and Circulation  
*Virgeen Healey*

Director of Marketing  
*Allison Pickell*

Production and  
 Circulation Coordinator  
*Jeremy Henderson*

Editorial Art Director  
*Irene Forbes*

Advertising Art Director  
*Matt Stewart*

Advertising Coordinator  
*Kristen Heldenbrand*

Marketing Assistant  
*Mitzi Tiffie*

Database Administrator  
*H.L. Moody*

Advertising Assistant  
*Greg Duszota*



**ARKANSAS BUSINESS  
 PUBLISHING GROUP**

Chairman & Chief Executive Officer  
*Olivia Farrell*

President and Publisher  
*Jeff Hankins*

Executive Vice President  
*Sheila Palmer*

© 2000 Arkansas Business Publishing Group  
[www.abpg.com](http://www.abpg.com)





Photo: A.C. Haralson / Arkansas Department of Parks &amp; Tourism

## DeGray Lake Resort

DeGray Lake Resort in Bismarck, a quiet island getaway surrounded by crystal waters and teeming with recreational opportunities, is Arkansas' only resort park.

Guests may enjoy any number of resort activities, including fishing, swimming and tennis. Or tee off at the resort's 18-hole, public championship golf course. The course offers a lighted practice and driving range and a practice green.

In addition, the staff at DeGray Lake Resort State Park regularly host guided horseback trail rides, scenic boat tours, nature walks and outdoor education programs. The park's biggest event, Eagles Et Cetera Weekend in January, celebrates the migration of bald eagles to DeGray Lake. Live eagles, hawks and owls are used in demonstrations, but the highlight of the event is the many tours to see wintering bald eagles in their natural habitat. For details, call (501) 865-2801.

Visitors who do not wish to camp may consider spending the night at DeGray Lodge, a 96-room newly renovated facility that spans the shoreline of DeGray Lake. The rooms feature a view of either the woods or lake, and all offer color cable television, room service and free accommodations for children 12 and younger. Amenities include an outdoor swimming pool, gift shop and business center. Rooms are \$70-80 per night. Call (501) 865-2851 or (800) 605-5675 for lodge reservations.

*DeGray Lake Resort State Park is off state Highway 7, northwest of Arkadelphia. For directions, call (501) 865-2108.*



# Arkansas Medical Society Insurance Programs....



## AMS BENEFITS, INC.

A wholly owned subsidiary of the  
Arkansas Medical Society

P.O. Box 55088

Little Rock, Arkansas 72215-5088

(501)224-8967

WATS 1-800-542-1058

FAX (501) 224-6489

"Available products include group  
health, office package, professional  
liability, home, auto, and more."

*tailor-made for physicians*

Insurance products are a fact of life. You can buy them almost anywhere. Fortunately there's one agency that only represents physicians...Arkansas physicians. AMS Benefits, with products to meet both your professional and personal needs.

Call us at 1-800-542-1058 or 501-224-8967





*There's nothing fair about treating physicians like fair game.*

**S**ome folks seem to think that taking pot shots at physicians is just good clean fun. We couldn't agree less. For 25 years, the physicians who operate SVMIC have dedicated themselves to providing the very best protection possible against medical malpractice litigation. As doctors, we know just how dangerous and unfair the world really can be. And, with our unrivaled risk management programs, no one can do more to prevent a physician from ever finding himself in the line of fire, than SVMIC.

For more information, contact Susan Decareaux or Thad DeHart • P.O. Box 1065 Brentwood, TN 37024-1065  
e-mail: [svmic@svmic.com](mailto:svmic@svmic.com) • Web Site: [www.svmic.com](http://www.svmic.com) • 1-800-342-2239 • (615) 377-1999



State Volunteer  
Mutual Insurance  
Company



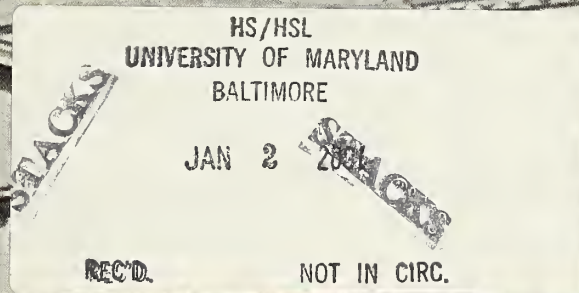
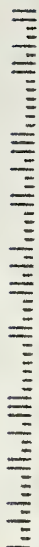
# THE Journal

OF THE ARKANSAS MEDICAL SOCIETY

Vol. 97 No. 7

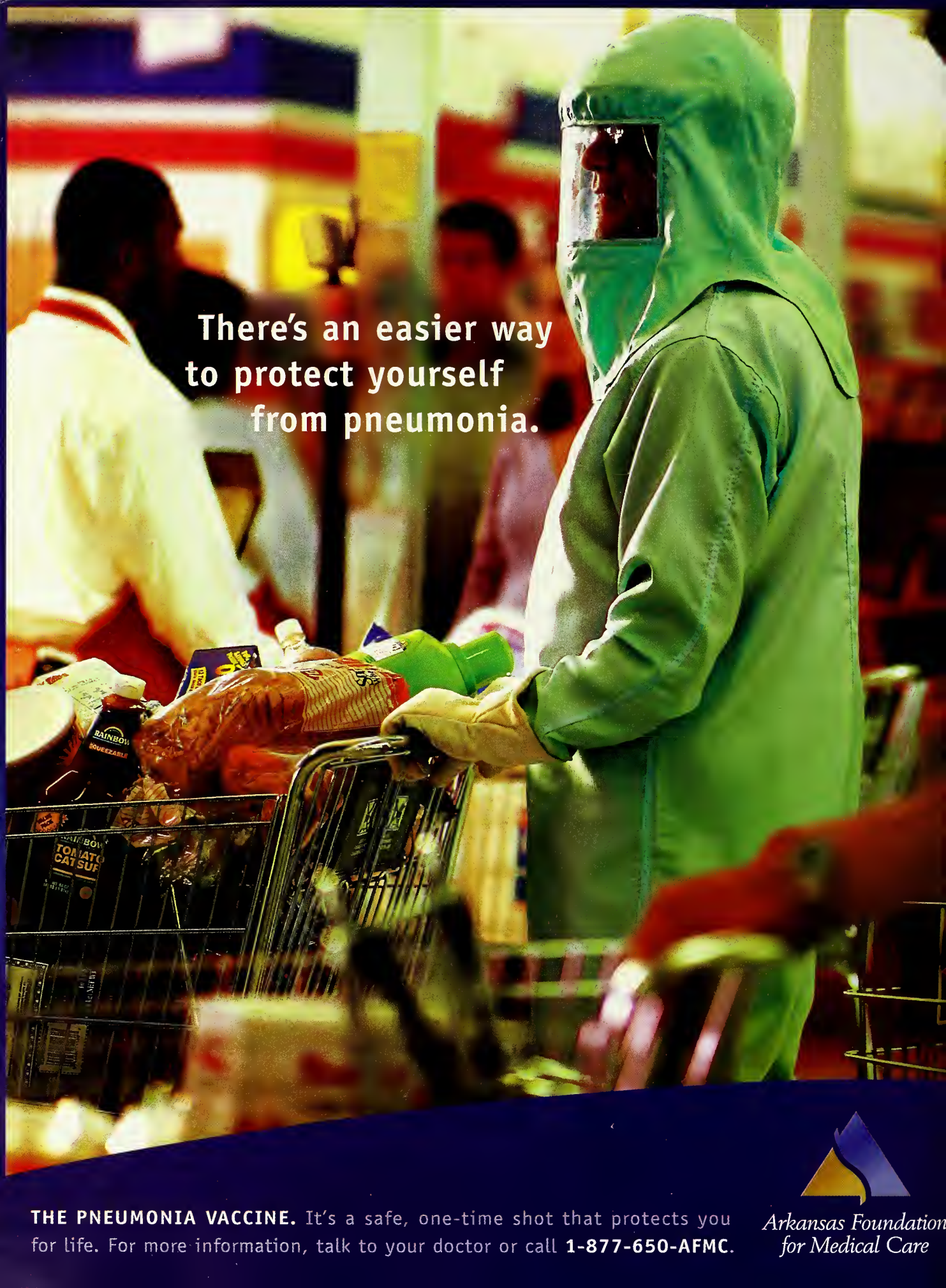
January 2001

\*\*\*\*\*MIXED ADC 640 S51 P8  
HEALTH SCIENCES LIBRARY  
UNIVERSITY OF MARYLAND  
COLLECTION DEVELOPMENT DEPT.  
601 W LOMBARD ST  
BALTIMORE MD 21201-1512



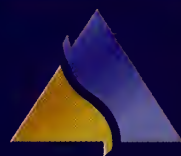
**Make Your Voice Heard  
During This Year's  
Legislative Session**



A person wearing a full-body white protective suit, including a hood and a clear face shield, is pushing a metal shopping cart through a grocery store. The cart is filled with various items, including a large bag of potatoes, a bottle of dish soap, and a box of tomato catsup. In the background, other people are visible, including a man in a white shirt and red apron. The scene is brightly lit, typical of a grocery store.

There's an easier way  
to protect yourself  
from pneumonia.

**THE PNEUMONIA VACCINE.** It's a safe, one-time shot that protects you for life. For more information, talk to your doctor or call **1-877-650-AFMC.**



*Arkansas Foundation  
for Medical Care*



# CONTENTS

## FEATURES

### 236 Health Care Issues a Major Focus for Legislative Session

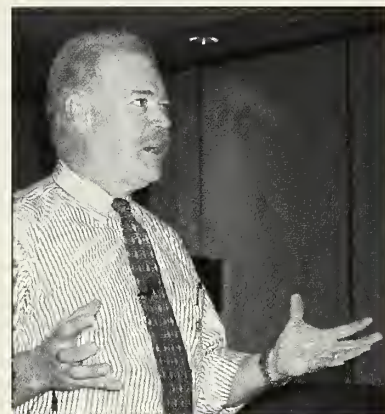
*AMS members have an opportunity to make a real difference this year during the Arkansas State Legislative session. Read about AMS' hot-button issues and what needs to be done.*

### 239 Fighting for AMS

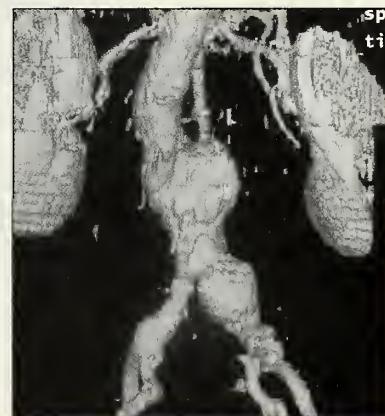
*Dr. Scott Ferguson, a former state representative, tells about his experiences as a lawmaker and why he thinks physicians should become involved in the process.*

### 250 Endovascular Repair of Abdominal Aortic Aneurysms

*In September 1999, the Food and Drug Administration approved two devices for the endovascular repair of abdominal aortic aneurysms. The endografts are placed from within the arteries using fluoroscopic guidance.*



Michael E. Dunn, a public affairs consultant in Arlington Va., urges AMS members to get involved in the political process.  
— page 236



New devices are now being used for endovascular repair of abdominal aortic aneurysms.  
— page 250

## DEPARTMENTS

- |                                       |                          |
|---------------------------------------|--------------------------|
| 232 Commentary<br>Jerry Kendall, MD   | 245 Radiology Report     |
| 232 Letters to the Editor             | 247 Surgery Report       |
| 235 What We've Done<br>For You Lately | 255 People + Events      |
| 241 Loss Prevention                   | 257 Arkansas Retreats    |
|                                       | 258 Index to Advertisers |

Cover Photo: Kirk Jordan





# Politics and Medicine

JERRY R. KENDALL, MD

I have never been a political animal. In fact, I would put politics dead last on my list of preferred vocations. However, I have voted in every election for the past 45 years. My father bought my poll tax (\$1) the first year that I voted and told me that if I had to skip a meal, I should save some back in order to exercise this privilege.

In our society, politics is the engine that drives the government and is the reason for social change, the success of the economy, and the quality of life that we enjoy. I believe that most politicians have an altruistic reason for running for office. They simply believe that they can make a difference in our government.

However, they are like many physicians: They are somewhat insecure and have a need to be needed and to be in a position of power. This may not be on a conscious level, and they may use this, as do many physicians, to do great good. In our society, nothing is needed more than dedicated, forward-thinking people in our political system. However, in many instances, it seems that the decision to be made when voting is who is the better of two poor choices.

This issue of *The Journal* focuses on the coming legislative session and profiles a former state representative, Dr. Scott Ferguson, who merged a successful medical practice with governmental responsibilities. The medical community is fortunate to have people like Dr. Ferguson who will get involved and work for the common good of us all.

Each of us, no matter how we feel about the political system, should have input to our representatives. Ever since the time of the framing of the U.S. Constitution, the argument has raged over the role of elected officials. Some said they should be emissaries of the people who vote the people's desires. Another school said that officials should

be elected who, because of their intellect, could make difficult choices that the populace was unable to do. Either way, they need to know the pulse of the region that they represent, and this is not possible without the necessary dialog between them and those whom they represent.

Every group and individual has a prioritized wish list. The mark of a good public official is how well he can walk that tightrope and negotiate compromise while providing a just and equitable balance between all factions. Unfortunately, there are times when doing the right thing means political suicide. Hopefully, when that occurs, our officials will see the job as bigger than themselves and have the integrity to do the right thing as they see it without regard to the prospects of re-election.

Sometimes we lose sight of the fact that medicine is still a respected profession. People still hold our opinions in high regard. And as a group, we wield an extraordinary amount of influence. But that influence is hidden under a bushel if we do not communicate with our representatives. Lobbyist Lynn Zeno and the Arkansas Medical Society do an outstanding job on our behalf, but how much more effective would it be if each of us individually contacted his or her representative on important issues?

In the final analysis, the aim of government officials and physicians should be that common denominator that binds us together: the benefit of the doctor's patients and the legislator's constituents. If that is the case, only good medicine and good government can ensue. ■

*Dr. Kendall is a retired family practitioner from Camden. He is a member of the editorial board for The Journal.*

Dear Sirs:

The article by Christy Smith on "The Big Easy" was of considerable interest to me since I had experienced many of the same things that were described.


However, I have an additional alternative to recommend for those who are tired of the rat race of private practice and frustrated by the perpetual conflicts between duty to patient care and the red tape of the current system.

At age 49, I took early retirement from a very profitable diagnostic radiology practice in Fort Smith, primarily to avoid the administrative hassles and conflicts I could see coming in the near future. Those political and economic conflicts were not what I entered medicine for, and I was gratefully out of the line of fire when the turmoil in Fort Smith peaked a few years later.

I used retirement to sail (my avocation of a lifetime) on the Atlantic, Mediterranean and Caribbean Seas, dive ancient wrecks, provide medical support for nautical archeology field trips, and to find out that all of these exotic things really meant a whole lot less to me than did the practice of medicine. Best of all, I found a route to satisfaction within the medical community that I had not been able to explore from private practice: academic interventional radiology.

After less than two years of retirement, I began a full-fledged vascular/interventional radiology fellowship, learned to temporarily live on a fellow's pay, and started a career not only doing clinical work — which was focused and the most exciting in my career — but also enjoying the interactions with residents in a teaching situation and interactions with others in the research portion of the specialty.

After six exciting years full of events that made medicine again important to me, I feel fully qualified to recommend this career track to others. Many of the skills learned in private practice do have application in the academic world, which currently depends more than ever  
(Continued on page 256)



**A**voiding litigation is always a good idea. In fact, staying out of the courtroom permanently is one of the trickiest, most brilliant procedures you may ever undertake. SVMIC places a unique focus on keeping our policyholders where they belong, at their patient's side and not stuck in some courtroom. We employ a full-time staff of attorneys that are available to all of our policyholders, even before a problem ever arises. Along with an entire battery of unrivaled risk management programs, they can keep the fickle finger of litigation from pointing at you.



State Volunteer  
Mutual Insurance  
Company

For more information, contact Susan Decareaux or Thad DeHart • P.O. Box 1065 Brentwood, TN 37024-1065 • e-mail: [svmic@svmic.com](mailto:svmic@svmic.com) • Web Site: [www.svmic.com](http://www.svmic.com) • 1-800-342-2239 • (615) 377-1999

**We all deserve our day in court, unless of course we can avoid it.**





# SUCCESS

Fantastic Tax  
Savings

# No Luxury Tax

# Prestige

# Power

*Fiser*  
**HUMMER**

Take the county line exit,  
1/2 mile down Hwy 5 towards Bryant.

**HUMMER**  
Undisputed **King** of Sport Utilities.

501.847.9043 1.800.776.4069

[www.fiser.com](http://www.fiser.com)

Two of the best financial  
planners in the nation  
are in Arkansas.

**CINDY CONGER**  
MBA, CPA/PFS, CFP

**RICK ADKINS**  
MBA, CFP, ChFC



They can be found at The Arkansas Financial Group.

Since 1985, we've been helping busy people make smart financial decisions. So next time you're looking for objective answers to life's crucial financial decisions, call The Arkansas Financial Group. You'll be in great company.

Here's what the editors of *Worth* and *Medical Economics* had to say:

*"The Best 150 Financial Advisers for Doctors, 8/00"*

*"The Best 250 Financial Advisers, 9/99"*

*"The Best 300 Financial Advisers, 9/98"*

*"The Best 250 Financial Advisers, 10/97"*

*"The 120 Best Financial Advisers for Doctors, 7/27/98"*

*"Fee-only, objective, customized, comprehensive, affordable advice"*

**The Arkansas  
Financial Group, Inc.**  
**376-9051**

PHOTO: KELLY QUINN/TERRITORIAL RESTORATION



COMMUNICATIONS COORDINATOR  
Judy Hicks

EXECUTIVE VICE PRESIDENT  
Kenneth LaMastus, CAE

ASSISTANT EXECUTIVE VICE PRESIDENT  
David Wroten

#### EDITORIAL BOARD

Jerry Byrum, MD	Pediatrics
Joseph M. Beck, II, MD	Oncology
Lee Abel, MD	Internal Medicine
Samuel Landrum, MD	Surgery
Jerry Kendall, MD	Family Practice
William Ackerman, MD	Anesthesiology

EDITOR EMERITUS  
Alfred Kahn Jr., MD

#### ARKANSAS MEDICAL SOCIETY 2000-2001 OFFICERS

Gerald A. Stolz, Jr., MD, Russellville  
*President*

Joe Stallings, MD, Jonesboro  
*President-elect*

Paul A. Wallick, MD, Monticello  
*Vice President*

Lloyd G. Langston, MD, Pine Bluff  
*Immediate Past President*

Carlton L. Chambers, III, MD, Harrison/Little Rock  
*Secretary*

Dwight M. Williams, MD, Paragould  
*Treasurer*

Anna Redman, MD, Pine Bluff  
*Speaker, House of Delegates*

Kevin Beavers, MD, Russellville  
*Vice Speaker, House of Delegates*

Joseph M. Beck, II, MD, Little Rock  
*Chairman of the Council*

**Established 1890.** Owned and edited by the Arkansas Medical Society and published under the direction of the Council.

**Advertising Information:** Contact Stephanie Hopkins, P.O. Box 3686, Little Rock, AR 72203; (501) 372-2816.

**Postmaster:** Send address changes to: *The Journal of the Arkansas Medical Society*, P. O. Box 55088, Little Rock, Arkansas 72215-5088.

**Subscription rate:** \$30.00 annually for domestic; \$40.00, foreign. Single issue \$3.00.

*The Journal of the Arkansas Medical Society* (ISSN 0004-1858) is published monthly by the Arkansas Medical Society, #10 Corporate Hill Drive, Suite 300, Little Rock, Arkansas 72205. Printed by The Ovid Bell Press, Inc., Fulton, Missouri 65251. Periodicals postage is paid at Little Rock, Arkansas, and at additional mailing offices.

Articles and advertisements published in *The Journal* are for the interest of its readers and do not represent the official position or endorsement of *The Journal* or the Arkansas Medical Society. *The Journal* reserves the right to make the final decision on all content and advertisements.

Copyright 2001 by the Arkansas Medical Society.

## WHAT WE'VE DONE FOR YOU LATELY



# What Have YOU Done For Yourself Lately?

BY DAVID WROTEN

**T**his month I'd like to turn the tables a bit. Rather than describing what the Arkansas Medical Society is doing to help Arkansas physicians, I'd like to ask what you are doing to help yourself, your patients and your profession? More to the point, what are you going to do?

In just a few short weeks the Arkansas General Assembly will convene at the state Capitol in Little Rock. They will consider more than 2,000 bills and resolutions. Nearly 200, or 10%, of those bills will be related to health care. Some will relate to public health, some will relate to health insurance, and some will likely relate to who can practice medicine. Some bills may affect how you practice in your profession, and still some may affect how and what you get paid. The bottom line is, all will have some impact on your patients.

The AMS has an effective governmental affairs program. We have a history of successful legislative efforts, and we have a full-time lobbyist at the Capitol every day. He happens to be one of the best in the business.

However, we are not legislators' "hometown" constituents. We can monitor the issues, provide truckloads of information and provide factual testimony in legislative hearings. But, they want to hear from YOU.

Only YOU, the legislators' treating physician or local neighbor, can best describe the hassles of arguing over the phone with a third-party payor for approval to treat your patients. YOU can best tell the legislator of the frustration of telling a patient that his insurance company won't pay for treatment that you think is medically necessary. YOU can explain why allied health professionals are not trained or qualified to diagnose. YOU can describe the plethora of problems associated with smoking and why we must concentrate on keeping tobacco out of the hands of our youth. The list of issues where only YOU are considered the expert is endless.

Let's face it. The legislature holds the key to who practices medicine and to some extent, how. Are YOU willing to just sit back and let others make decisions that affect you and your patients or are YOU willing to take an active role in the process? Physicians are the most respected members of the community. Your thoughts and opinions have a major influence on legislators.

What are you going to do for yourself and your patients? Here are a few things you can do to make a difference. First, read the legislative updates we send to your home each week during the legislative session. When asked to contact your legislator on specific legislation, do it immediately, keeping in mind that it is you who needs his or her help. Make a commitment to attend the AMS Day at the Capitol on Jan. 31. Nearly every legislator attends our reception. When they ask, "Who is here from my district?" it looks really bad when we have to say, "No one."

By your active involvement, YOU can truly impact the future of medicine and patient care. ■



# Making it Count

## Physicians Urged to Take Active Role in Political Process

By Christy L. Smith



Public affairs consultant Michael E. Dunn addressed AMS members at the 2000 fall meeting.

**T**he needs of Arkansas physicians and patients will continue to be ignored unless health care providers decide to quit being victims, physicians were told at the Arkansas Medical Society's 2000 Fall Meeting in late October.

Michael E. Dunn, president of Michael E. Dunn and Associates Inc., a public affairs consulting company based in Arlington, Va., was the keynote speaker. He delivered a quick civics lesson, outlining how the American political system works and why it is important to be involved, and coached the physicians on how to be effective participants.

After Dunn completed his presentation, Lynn Zeno, director of governmental affairs for the AMS, offered physicians an overview of the issues the state Legislature might propose or consider when it convenes in January.

About 75 member physicians attended the AMS meeting, held Oct. 29 at the Embassy Suites in Little Rock. It is held every two years to inform members about the issues that will most likely be proposed or considered during the Arkansas General Assembly.

Here's a look at the presenters and what they had to say:

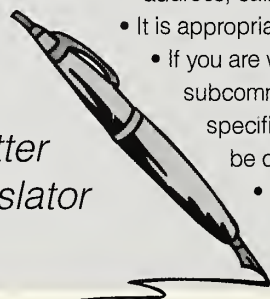
### Political Involvement

Dunn, who addressed the AMS 13 years ago when the organization was considering whether to hire a governmental affairs liaison, travels the country, helping corporations and trade and professional associations become more politically effective through political action committees, grassroots lobbying programs and political education programs.

At the 2000 Fall Meeting, Dunn reminded physicians that issues that affect them are often determined by legislators who have no background in health care and that physicians are the most qualified to convey their needs and the needs of their patients to lawmakers.

## The Power of the Pen

### Tips for Writing an Effective Letter to Your Legislator



- Use the title "Honorable" to show respect for our system of government and those who died defending it.
- Always include your congressman's office or suite number and the number of his building in the address line. This ensures proper delivery of your letter. If you do not know the specific address, call and find out.
- It is appropriate to call a legislator by his first name only if you know him personally.
  - If you are writing about a certain piece of legislation, cite the bill number, the bill title, the subcommittee that is considering the bill, what action is pending on the bill and what specific issue you want the congressman to address. If you are not specific, you will be disappointed with the response.
  - Never use a threatening or rude tone. This approach is counterproductive.
  - Keep your letter short and to the point. No one is going to read it if it's longer than one page.

He urged physicians to become friendly with their legislators and their legislators' staffs, to write letters to their congressmen, to donate to the campaigns of candidates who might be sympathetic to physicians' needs, and to remain informed about health care issues being considered at the state and federal levels.

"Whether you like politics or not is immaterial," he said. "The future of medicine here in the United States will be determined by decisions made by Congress and your state Legislature."

If physicians do not become involved in the policymaking process, they will no longer have control over the way they practice medicine, Dunn said.

"There will be more and more people telling you what to do," he said.

Most Americans "don't have the foggiest idea" how public policy is made, he said, but "my goal is to make sure that what you say to your lawmaker makes a difference in how that lawmaker decides to vote."

According to Dunn, physicians need to remember two key points about the political system before they can be effective participants: Compromise plays an integral role in determining public policy, and those who control the political environment will control the way policy issues are determined.

When legislators compromise on issues, there is always a winner and a loser, Dunn said.

"There has never been a bill enacted into law that universally benefited everyone. Every time a legislator determines a matter of public policy, there will be people who win as a result of that law, and there will be people who lose as a result of that law," he said.

If physicians want to be winners in the American political process, they must make their needs and views known to their legislators, Dunn said.

"We live in a highly competitive, special-interest democracy. A fatal flaw of a representative democracy is that it only represents those who get involved. You are either a player or a victim," Dunn said. "This is a call to action to get ready for January. If you are not ready for January, you are not going to like what happens to you."

In addition to being president of Michael E. Dunn and Associates, Dunn is president of Public Affairs Video Enterprises Inc., a

## Internet Savvy Physicians



Arkansas physicians can now contact their state and federal lawmakers with the click of a mouse. The Arkansas Medical Society's Web site now features a link to the American Medical Association's Grassroots Action Center.

This feature allows member physicians to look up the names and contact information of their state and federal lawmakers and then send them an electronic message. Physicians simply enter their ZIP codes in the appropriate field and hit the search

button. Then a list of their lawmakers appears.

By clicking on the name of a lawmaker, physicians may access a biography and photo. Most lawmakers have an e-mail address as well as a snail mail address, so physicians may send an electronic message. If a lawmaker does not have an e-mail address, physicians may send a traditional letter.

But would a lawmaker take an e-mail as seriously as he would a handwritten letter?

Dr. Scott Ferguson, a diagnostic radiologist from West Memphis and former state representative, seems to think so.

"I think it is very effective," he said at the 2000 Fall Meeting. "They'll read [the e-mails] if you personalize them."

The AMS Web address is [www.arkmed.org](http://www.arkmed.org). Click on the Grassroots Action Center icon to begin accessing the database of legislative information.

media communications corporation dedicated to producing innovative public and governmental affairs video programs for the business, trade and professional communities.

He is on the board of directors of the Public Affairs Council in Washington, D.C., and the Arlington Free Clinic, which provides health services to the needy.

Before establishing his own companies, Dunn was director of government relations services for the Public Affairs Council, the national professional organization for business public affairs executives.

Dunn also was legislative assistant for two former U.S. representatives — David Pryor, D-Ark., and G.V. "Sonny" Montgomery, D-Miss. Before moving to Washington 26 years ago, Dunn taught political science at the University of Arkansas at Monticello. He is a native of Magnolia. Dunn and his wife, Mary, have one daughter, Meredith.

### Health Care Issues

In January, a new group of state and federal lawmakers will convene, Zeno said. Many of the thousands of proposals that will

be considered by lawmakers next year will affect how physicians practice and what services patients may obtain, he said.

"Ninety-nine percent of all medical issues are black and white. They are either good for patients and doctors, or they are bad," he said.

Some of the health care issues that may be considered at the state level are prompt payment, prohibition of "all products" clauses, fee schedule disclosure, drug recycling in nursing homes, smoking prohibitions in public places, gunlock requirements for stored firearms, bottle rocket prohibition, prohibition of minors in pickup truck beds and repeal of the soft drink tax, Zeno said.

"Many of these are repeats, and we fight them every two years," he said.

Zeno said Arkansas physicians are concerned about prompt payment because some insurance companies take as long as 120 days to reimburse physicians for their services, whereas the regular consumer is expected to remit payment for a bill within 30 days.

"Prompt payment is the biggest issue I hear about from members," he said.

Zeno said he would like to see approval



of legislation requiring third-party payers to remit payment for electronically submitted "clean claims" within 30 days and for manually filed "clean claims" within 45 days.

He said third-party payers should request additional information for a "non-clean claim" within 30 days and then remit payment for the claim after 30 days. A penalty also should be assessed against insurance companies that fail to pay claims in a timely manner, he said.

Another insurance issue is the all-products clause, which, in contracts between physicians and third-party payers, stipulates that if a physician signs up for one of an insurance company's programs, he automatically signs up for all the programs, Zeno said. The medical Society will most likely push for a prohibition of these contractual arrangements, he said.

The society also will support any attempt to require insurance companies to publicly disclose the dollar amount they will reimburse a physician for specific services, proposals to require nursing homes to use the unopened drugs of a deceased patient rather than discard



*Dunn, Lynn Zeno, AMS director of governmental relations; and Dr. Joe Stallings, AMS president-elect; at the fall meeting.*

them, and measures to prohibit smoking in public places such as restaurants, Zeno said.

Public health issues such as gunlock requirements and prohibition of bottle rockets and of minors' riding in truck beds are likely to be raised during this year's legislative session, Zeno said.

And while the society would support such proposals to ensure the safety of Arkansans, they would probably not fare well in the Legislature, he said.

"There are four things you don't mess with in the state Legislature — dogs, pickup trucks, guns and fireworks," Zeno said.

And while there are plenty of proposals the medical society would support, a repeal of the soft drink tax is not one of them, he said.

In 1992, the state Legislature passed a 2-cent tax on all bottled and canned soft drinks to help support the state's Medicaid trust fund. The tax generates about \$50 million a year. The federal government matches it, 3 to 1, generating about \$200 million annually, but the Medicaid fund still comes up short, Zeno said.

A tobacco settlement that Arkansas voters approved Nov. 7 will help alleviate that Medicaid shortfall by pouring about \$17 million into the fund annually, Zeno said. Some opponents of the soda tax may argue during the next legislative session that it is time to repeal it because an alternative source of Medicaid funding has been approved, he said.

"The AMS would be opposed to any proposal that might jeopardize funding of the Medicaid trust fund," Zeno said. ■

## Collect Bad Debt

- Cheaper
- Faster
- In compliance with the Law



**We Collect  
Arkansas**

If you've always used a  
collection agency. . . WHY?

Cut out the collection agency by  
retaining the Maggio Law Firm.

Save time. Save money.  
Be in compliance with the law.

Have you always used a collection  
agency because "that's the way  
you've always done it?"

*Try a new way. . . tip the scales in  
your favor, call Mike Maggio today.*

## MAGGIO LAW FIRM

*your collection law firm*

Offices in Conway and Searcy • 1-800-600-3201

[www.ebaddebt.com](http://www.ebaddebt.com)

# Meet Our Members

## Scott Ferguson, MD

By CHRISTY L. SMITH

Dr. Scott Ferguson knows what it's like to be the only doctor in the house.

The 49-year-old diagnostic radiologist from West Memphis served two terms in the state House of Representatives. Because he was the only physician serving in the House from 1992-98, other legislators went to him for advice about health care issues.

"I was the only freshman member of the Public Health, Labor and Welfare Committee because I was viewed as an expert in that area," Dr. Ferguson said. "The other committee members looked at me to find out how a bill would impact patients."

Of course, being the answer man can be stressful, Dr. Ferguson acknowledged.

"I really had to get up to speed quick," he said. "I knew from my everyday working experience how [laws] would impact patients, but I didn't know the intricacies of health care policy. I was thrown into the arena, and I had to learn. It was very stimulating and very educational."

Dr. Ferguson's interest in politics and medicine was culled from his parents, he said. Joyce Ferguson Wyatt was a grassroots activist who became mayor of West Memphis, and Thomas Murray was an obstetrician and gynecologist who encouraged his son to pursue a career in medicine.

"My mother, back in the '60s, led the fight for fluoridation of water. She became mayor of the town in the '70s and was the first female mayor of a first-class city," he said.

Dr. Ferguson completed his premed requirements at Memphis State University and graduated from American University of the Caribbean in Montserrat, British West Indies, in 1981. He completed a one-year rotating internship at Lloyd Nolan Hospital in Birmingham, Ala., and a diagnostic radiology residency at Baptist Memorial Hospital in Memphis. He began

practicing at Outpatient Radiology Clinic in West Memphis in 1985.

Dr. Ferguson said he entered the political arena in the early 1990s because managed care caused him to stop seeing about 40% of his patients whose insurance companies required them to see doctors in Memphis.

"I was interested in making sure that people in our town could see the doctor of their choice," he said. "I was encouraged that the state Legislature is a place where you can have an impact."

Dr. Ferguson credits his election victories to the support he received from the Arkansas Medical Society, his fellow physicians and his local constituents. During his tenure in the Legislature, Dr. Ferguson sponsored the 1995 "any willing provider" bill, which allowed patients to go to the doctor of their choice. The measure was unanimously approved in the Legislature but was later overturned by a federal court, Dr. Ferguson said.

In 1997, he sponsored the Health Care Consumer Act. The measure prohibits gag clauses in insurance contracts, gives new

---

*Dr. Scott Ferguson, a former state representative from West Memphis, was often the "go-to man" when it came to health care issues up before the state Legislature.*

Photo: Kirk Jordan





mothers the choice of remaining in the hospital for 48 hours rather than being discharged after only one day, and requires insurance companies that pay for a mastectomy to also provide coverage for reconstructive surgery or prosthetic devices, among other provisions.

Also in 1997, Dr. Ferguson co-sponsored legislation to establish ARKids First, a program designed to insure the children of working families who cannot afford to purchase health insurance, and the Comprehensive Health Insurance Pool for high-risk individuals who cannot otherwise get insurance.

Dr. Ferguson said his stint in the House of Representatives has been the "single greatest learning experience" of his life so far.

"I had a great experience in the House of Representatives," he said. "I was meeting people from all walks of life, from all over the state, who had different perspectives and different ideas."

Physicians who think politics and medicine are at opposite ends of the spectrum are mistaken, Dr. Ferguson said.

"As doctors, we try to take care of

patients. We try to heal people and make them better," he said. "In the Legislature, you can have such an impact on the whole state, on the people's needs. It's a slower process, but it certainly has a greater impact on a larger number of people."

Dr. Ferguson left the state House to try national politics. He competed against U.S. Sen. Blanche Lincoln, D-Ark., in the 1998 Democratic primary.

Although he was unsuccessful in that attempt, he said it is important for him — and his colleagues — to remain involved in the legislative process.

"There are a lot of decisions made every day that directly affect patients and the medical community that are made by people who have no working knowledge of medicine. Legislators depend upon the Arkansas Medical Society and their local doctors to educate them," he said. "So often, doctors want to take care of patients and then be left alone. But I think we've seen what affect that attitude has. Things will go contrary to good public health; things will go contrary to our patients."

Dr. Ferguson said he will be keeping an eye on several issues during the coming

Arkansas General Assembly but that the soda tax is foremost on his mind.

"The tobacco referendum just passed, and it is going to do a lot of wonderful things for health care, but there is a fear among people involved with politics and the medical community that there will be a push to repeal the soda pop tax," he said.

The 2-cent tax, approved by the Legislature in 1992 as a levy on bottled and canned soft drinks, generates about \$50 million annually for the state Medicaid fund. Those funds are matched 3-to-1 by the federal government, so a repeal of the soda tax could cost the state \$200 million, Dr. Ferguson said.

Dr. Ferguson has been a member of the Arkansas Medical Society since 1985. He is chairman of the Society's governmental affairs committee, which decides how the Society's political action committee will spend its money and what issues the Society will get involved in.

Dr. Ferguson's wife, Deborah Ferguson, is a dentist in West Memphis. Dr. Ferguson and his wife have three children — Catherine, an 18-year-old high school senior; Scott Jr., 15; and Caroline, 9. ■



## ***ARE YOU LOOKING TO SLOW DOWN?***

**Arkansas is the place for you!**

**Staff Physicians and Medical Directors Needed.**

Primary & Supplemental Opportunities available in Heber Springs, Jonesboro, Searcy  
Walnut Ridge, Wynne. Annual Volumes Range 6,500 to 35,000.

Must be BC/BP EM or PC, Residents welcomed in some locations, ACLS/ATLS/PALS.

PhyAmerica offers competitive remuneration, IC status and procured malpractice.

For more information on this and other opportunities in Arkansas, please contact

**Traci Mahlmeister**, *Physician Recruiter* at PhyAmerica Physician Services,  
800-476-5986, fax CV to 919-382-3274, or e-mail [tmahlei@phyamerica.com](mailto:tmahlei@phyamerica.com).





# Trauma-What Were the Facts?

J. KELLEY AVERY, MD

Medical malpractice cases are not lost because of errors in judgment. They are lost when the judgment errors do not follow careful use of all the data available, and the case is not handled in a logical and sound fashion based on the information the physician has.

## Case Report

On an icy road early one morning while driving his wife to work, the husband suddenly encountered a line of cars involved in an accident. He swerved to avoid the car in front of him, skidded sideways, and was struck broadside by a car following him. Both he and his wife were taken to the nearest hospital emergency department. She was treated for minor injuries and discharged. Her husband, however, was more seriously injured.

The evaluation of the husband was done initially by an ED physician who was finishing up his shift, and it was completed by the physician's relief, who had just arrived in the ED.

The patient's complaints were chiefly of pain and swelling of the right hand, some epistaxis and facial contusions. The past medical history revealed emphysema, but the patient denied having any other medical problems.

The examination revealed some bleeding from the nose, which had largely stopped, and some swelling and tenderness of the face. The notes reveal that the patient wore upper and lower dentures. The remainder of the assessment was unremarkable except for the swelling, tenderness and crepitation over the dorsum of the right hand. At the time of the evaluation, the patient was wearing a Philadelphia collar that had been put on him by the paramedics at the scene. Vital signs were stable, and the patient was sent to the X-ray department for studies of the skull, cervical spine and right hand.

He then complained of feeling faint and stated, "I'm going to pass out." After receiving IV fluids, he seemed to feel much better. The CT scan of the head was reported negative, as were the X-rays of the cervical spine. The hand showed displaced fractures of the second and third metacarpals, and the orthopedic surgeon on call was notified.

Since the patient seemed stable and the roads were very dangerous, both the ED physician and the orthopedic consultant agreed the patient would be admitted to the outpatient service for a short stay so that he could be more thoroughly evaluated when getting to the hospital would be safer for the orthopedic surgeon. Later that day, the surgeon did come and scheduled the patient for reduction and pinning of the fractures the following morning.

The record does not contain an examination by the surgeon, but the nurse anesthetist's evaluation revealed no contraindication to general anesthesia. The examination did reveal a statement, "Dentures or capped teeth-edentulous."

Reduction and pinning was accomplished without incident under general anesthesia, postoperative assessments were carried out appropriately, and the patient was discharged from the recovery room. The patient complained of pain in his left knee, but X-rays were negative. The nurse removed a small piece of glass from the patient's gum line. There was some disagreement as to whether or not the nurse notified the surgeon about this. The patient was then discharged with appropriate instructions.

The patient's wife stated she tried to contact the surgeon on several occasions because her husband was having difficulty swallowing but that she was unsuccessful. She had been given instructions at the time of discharge as to how to contact the doctor. There was no resolution to this problem as far as the patient was concerned.

However, the patient, as instructed, returned to the surgeon's office two days after being discharged from the hospital. The patient's complaints were principally that he had some bleeding through the dressing on the hand and that he was having more difficulty swallowing.



# Medical Practice Consultants, Inc.

An Arkansas-Based Firm with Over 75 Years  
of Medical Practice Knowledge

- Custom-Designed Compliance Program
- Coding and Documentation Evaluations
- Practice Assessments With Reports

Call 1-870-236-1899

for information on affordable services  
designed to meet YOUR medical practice needs



Donald B. Smith	— CEO
Benjamin "Mac" Butler	— Consultant
Patty Pendergrast	— Consultant

## ACHIEVING SUCCESS ENTITLES YOU TO PRIVILEGES IN LIFE

Achieving your personal goals often requires a planned balance of financial management, including checking, loans, trust, investment products\* and services.

At Regions, we offer Private Banking to complement your success. We provide a level of service to efficiently meet your needs and maximize your valuable time. Whether you require business or personal services, you can rely on one of our private bankers to help ensure your goals are met by providing uncompromising, convenient service. To find out more about the special attention you deserve, please call us today.

Contact our Private  
Banking Department  
371-6613

PRIVATE  
BANKING

Regions Bank

[www.regionsbank.com](http://www.regionsbank.com)



\* Investments purchased through Regions Investment Company, Inc. are not deposits of the bank or guaranteed or insured by the bank, the FDIC or any government agency. Investments can assume risk including loss of principle. Regions is a member of NASD and SIPC.

MEMBER  
FDIC

In the office note, the surgeon reported the changing of the dressing and stated, "Comorbid conditions include lacerations about the mouth treated by the ED physician. The patient apparently strained his neck, has some swallowing difficulty ... I'd like to monitor him for this and perhaps obtain appropriate studies if his symptoms of swallowing difficulty continue."

During the next 24 hours, the patient developed some increased difficulty breathing and swallowing, and his wife was told by the surgeon's office to take him to the hospital immediately.

He was admitted to a different hospital (the surgeon's primary hospital) on this occasion. He was nauseated, weak, somnolent and hallucinating. His shortness of breath and dizziness had worsened since the office visit of the day before. His blood pressure was 90/40 mm Hg, he was dyspneic, and he had a poor urinary output.

On examination, a firm swelling in the left side of the neck was found, with ecchymoses extending inferiorly into the auxiliary area. Further X-ray studies revealed retropharyngeal air extending over the area of the neck where there appeared to be a "radiopaque foreign body which bridges the area of the retropharynx and extends into the pharynx itself."

He was in a state of septic shock, which progressed to multisystem failure requiring aggressive antibiotic and fluid/electrolyte support. Renal failure indicated the need for renal dialysis.

On  
examination,  
a firm  
swelling in  
the left side  
of the neck  
was found,  
with  
ecchymoses  
extending  
inferiorly into  
the axillary  
area.



During the severe hypotension associated with the sepsis, the patient developed severe ischemic gangrene of the extremities, resulting in the amputation of one hand, three fingers on the other hand, and both legs below the knee. The patient survived and was discharged after about three months in the hospital.

While in the hospital during the two admissions, the patient was treated by two ED physicians, a radiologist, an orthopedic surgeon, an internist, an infectious-disease specialist and a nephrologist.


Lawsuits for failure to diagnose the esophageal tear were filed against the orthopedic surgeon, the anesthesiologist and the ED physician at the first hospital to which the patient had been admitted.

A thorough investigation revealed significant problems for all the physicians sued. A jury trial of these complaints seemed out of the question because of the extensive damage that resulted to the patient during this extremely critical disease process, and the sympathy that would naturally be present. The settlement for all physicians combined was in the high six figures.

## Loss Prevention Comments

The details of the initial evaluation were very poorly documented. The issue of the dentures was not part of the record. Both the patient and his wife contended that they had told all the physicians and the anesthetist of his "swallowing his teeth" and his difficult removal of them from deep in his throat using his fingers. Although this fact was nowhere documented in anybody's record, the bleeding from the mouth and the difficulty swallowing were mentioned in multiple places by several caregivers.


The first X-ray of the cervical spine revealed the retropharyngeal air, which was missed by the radiologist. The only physician note about the swallowing difficulty was that of the orthopedic surgeon, who, on the visit two days after the initial discharge,




*Introducing the*


# DIAMOND STAR

**Fast: 147 Knots / 169 MPH**  
**Affordable: Ownership from 25% to 100%**  
**And Fun!!!**

 **CENTRAL**  
FLYING SERVICE

Call Cheri McKelvey  
501-975-9321

 **SKYSHARE**



Healthcare Professional Liability  
 Business/Workers' Compensation/Life & Retirement  
 Planning


Managing the business side of healthcare is time consuming, but FARMERS helps get you back where you belong—delivering quality medical care.

For almost 50 years, Farmers Professional Liability has specialized in providing coverage and risk management solutions to the changing liability risks associated with the delivery of healthcare.


Our Physician Program offers solutions to, and exacting coverage for, today's broad spectrum risk exposures.

We make it simple—with one call we can handle all your insurance needs!

**Symbol of Superior Service**



Mark Perry  
 112 Municipal Drive  
 Jacksonville, AR  
 72076  
 (501)982-4561  
 1-800-467-2436  
 mperry@alltel.net



Joanna Owens  
 712 A Bradley Dr  
 Mtn. Home, AR 72653  
 (870) 424-2120  
 1-888-424-2120  
 baxterinsurance@yahoo.com



# ARKANSAS

## EMERGENCY DEPARTMENT OPPORTUNITIES

# EmCare

Leader in Physician Practice Management

### BAPTIST MEMORIAL HOSPITAL – BLYTHEVILLE, ARKANSAS

- 16,000 Annual Patient Volume
- 12 Hour Shifts
- New 8 Bed ED
- BP/BC EM or PC
- Relocation Allowance
- Signing Bonus

### CRITTENDEN MEMORIAL HOSPITAL – WEST MEMPHIS, ARKANSAS

- 17,000 Annual Patient Volume
- 12 Hour Shifts
- 10 Bed ED
- BP/BC EM or PC
- Relocation Allowance
- Signing Bonus

For more information contact: **Lisa Clayton @ (800) 362-2731 ext. 2718**

Fax C.V. to: (214) 712-2444 or

Email: [Lisa\\_Clayton@EmCare.com](mailto:Lisa_Clayton@EmCare.com)

**The EmCare Mission:** *To serve and support physicians, hospitals, and other healthcare clients in providing high-quality patient care.*

**We Offer Competitive Compensation & Excellent Benefits**

An Equal Opportunity Employer

[www.EmCare.com](http://www.EmCare.com)

documented the complaint and speculated about a follow-up by another specialist. However, during the visit, he did not look at the patient's mouth or throat.

The proof developed after the lawsuit was filed indicated that both the anesthetist who did the initial preoperative evaluation and the anesthesiologist who put in the endotracheal tube should have seen the lesion in the throat. Had the surgeon examined the patient's mouth and throat two days before his last admission, he might well have seen the injury in the throat and effected an appropriate intervention.

Even without the swearing contest of the patient and his wife with all the physicians involved, there was enough expert testimony putting all of them outside an acceptable standard of care. The radiologist did not report the retropharyngeal air that was subsequently seen on the initial films. The ED physician in the first admission note did not document any assessment of the throat or mouth as a result of the history of "swallowing his dentures." The surgeon paid more attention to the swallowing problem than did anyone else, but he did not look into his patient's mouth. All this, in the face of consistent testimony of the patient and his wife that they told the story of his swallowing his teeth multiple times, was extremely weak.

It is almost a rule in medical liability litigation that a swearing contest between the physicians and the injured patient is consistently lost by the doctor in the absence of contemporaneous documentation to the contrary. ■

*Reprinted from a November 1999 issue of Tennessee Medicine. The Case of the Month is taken from actual Tennessee closed claims. An attempt is made to fictionalize the material in order to make it less easy to identify. If you recognize your own case, please be assured that it is presented solely for the purpose of emphasizing the issues presented.*

# UAMS

continuing  
medical  
education



Office of Continuing Medical Education. . .  
*Committed to Life-Long Learning*

### 2001 Programs

- |            |                                                                                                                                                       |
|------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| Feb. 9-10  | Geriatric Medicine Update<br>Location: DoubleTree Hotel                                                                                               |
| Mar. 2-3   | Neurology for the Non-Neurologist<br>Location: UAMS Pauly Auditorium, Ed III Bldg.                                                                    |
| Mar. 11-16 | Annual Conference of the UAMS-Prosper Meniere Society<br>Location: Inn at Aspen, Aspen, CO                                                            |
| Mar. 21-24 | Southern Group on Educational Affairs<br>Location: Excelsior Hotel, Little Rock, AR                                                                   |
| Apr. 5-7   | Symposium on Critical Care and Emergency Medicine<br>Location: Arlington Resort Hotel, Hot Springs, AR<br>Joint Sponsors: UAMS and Univ. of Tennessee |

**For additional information,**  
call the Office of Continuing Medical Education at (501) 661-7962  
or check our website, [www.uams.edu/cmefd/cme2.htm](http://www.uams.edu/cmefd/cme2.htm)



## Allergic Fungal Sinusitis Has Become Common

**AUTHORS:** CHARLES M. BOWER, MD — TRACEY D. STEWART, MD

**EDITOR:** STEVEN R. NOKES, MD

### History

A 10-year-old girl presented with severe headaches, nausea, vomiting and dehydration. She was afebrile. A CT scan of the head was performed (Fig. 1 & 2), which prompted an MR scan (Fig. 3 & 4).

### Findings

The CT scan reveals a 4-by-3-cm

expansile mass centered in the sphenoid sinus, which is hyperdense and does not enhance. On MR imaging, the sphenoid mass has a laminar appearance with an intermediate signal intensity on T1 weighting and decreased signal intensity on T2 weighting. Peripheral rim enhancement is noted, with enhancing tissue extending

through the sphenoclinoid synchondrosis along the clivus.

### Diagnosis

Allergic Fungal Sinusitis (AFS)

### Discussion

Fungal sinus disease, once considered uncommon, has increased

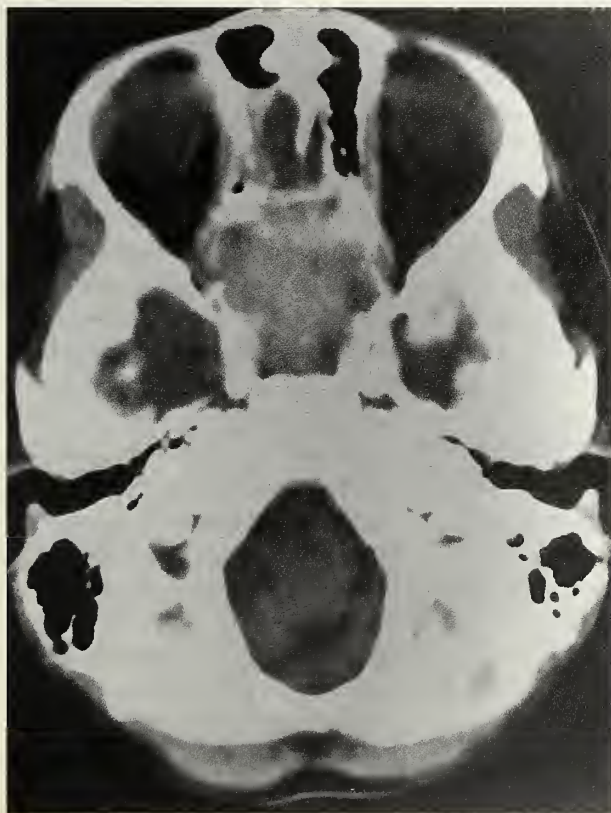


Fig. 1. CT scan without contrast.



Fig. 2. CT scan with contrast.





**Fig. 3.** Sagittal T<sub>2</sub> weighted (4000/80). MR of the brain without contrast.



**Fig. 4.** Sagittal T<sub>1</sub> weighted (500/12). MR of the brain with contrast.

dramatically over the past two decades. The classification scheme recently changed with an increase in the understanding of the disease. Fungal sinusitis is broadly divided into invasive and noninvasive forms. Invasive fungal sinusitis includes acute fulminant fungal sinusitis, granulomatous invasive sinusitis and chronic invasive fungal sinusitis. Invasive fungal sinusitis may be rapidly progressive and fatal. Noninvasive fungal sinusitis is subdivided into fungus ball and allergic fungal sinusitis, both of which are rarely fatal.

AFS is now thought to be the most common form of fungal sinusitis. Nasal obstruction, rhinorrhea and facial pressure are common symptoms. Most patients have obvious nasal polyps. AFS is a disease of young adults (most commonly 20- to 30-year-olds) who live in warm, humid climates. It is characterized by the presence of allergic mucin in the involved sinus. Allergic mucin is composed of laminated collections of intact and degenerated eosinophils, Charcot-Leyden crystals, cellular debris and hyphae which do not invade mucosa. Originally thought to be solely caused by *Aspergillus*, several other common

fungi including *Curvularia*, *Bipolaris*, *Pseudallescheria* and *Fusarium* have been implicated.

AFS continues to be underdiagnosed. CT and MR play an important role in suggesting the disease, allowing prompt and effective therapy. Treatment differs from other forms of fungal sinusitis and involves functional endoscopic surgery with adjunctive systemic and intranasal steroids to decrease the abnormal immune response. Systemic antifungal agents play no role in the treatment. Allergen immunotherapy to downregulate the production of fungus-specific immunoglobulin E holds promise. Recurrence of polyps is not uncommon.

CT reveals a hyperdense mass in the affected sinus due to a combination of heavy metals (iron and manganese), calcium and densely packed hyphae. The sinus is almost invariably totally opacified and expanded. Extension into adjacent structures occurs in 20%, usually intracranial or intraorbital.

MR demonstrates low signal on T<sub>2</sub> weighting due to an absence of mobile protons and the heavy metals. This appearance is not specific, however; and occurs in any inspissated,

chronically obstructed sinusitis. The signal characteristics can mimic normal aeration at MRI, resulting in gross underestimation of disease.

Differential diagnosis would include chordoma, sinonasal meningioma or a sarcoma with a chondroid matrix. All of these would be expected to be less homogeneous on CT and enhance to some degree. The laminar appearance on MR with peripheral enhancement would be highly unlikely in these tumors. ■

*Dr. Nokes is with Radiology Consultants of Little Rock. Dr. Bower is with the University of Arkansas for Medical Sciences and Arkansas Children's Hospital. Dr. Stewart is in private practice.*

## References

1. Mukherji SK, Figueroa RE, Ginsberg LE, et al: Allergic fungal sinusitis: CT findings. *Radiology* 1998; 207: 417-422.
2. Fatterpekar G, Mukherji SK, Arbelez A, et al: Fungal diseases of the paranasal sinuses. *Sem in US, CT and MRI* 1999; 20: 391-401.
3. Deshazo RD, Chapkin K, Swain RE: Fungal sinusitis. *N Engl J Med* 1997; 337: 254-259.



# SURGERY



## Open versus Thoracoscopic Removal of Left-Sided Mid-Esophageal Leiomyoma

A.H. Rusher, MD, FACS — Kim Davis, MD — David Phillips, MD — L. Wiggins, MD, FACS

### Introduction

Although esophageal leiomyomata are benign tumors, it is generally recommended that they be surgically removed due to the associated morbidity. The most common complaints as this benign smooth muscle tumor enlarges are dysphagia, retrosternal pain, regurgitation, weight loss and vomiting. Traditionally, either a right or left thoracotomy was an acceptable approach, depending on the location of the tumor. The literature recommends that upper- and mid-esophageal tumors be approached with a right thoracotomy and that lower esophageal tumors be approached from the left.<sup>1</sup>

More recent articles have explored the use of thoracoscopy for removal of these benign tumors.<sup>2</sup> In most cases of simple leiomyoma, it is reportedly safe and effective to remove these tumors thoracoscopically.<sup>3</sup> Even using the thoracoscope, the recommendation has remained the same for the side of approach for the level of tumor.<sup>4</sup> This case presentation is to suggest that left-sided esophageal leiomyomata may be approached from a left-sided thoracotomy or thoracoscopy from the lower esophagus up to the level of the aortic arch.

### Case Report

The patient is a 53-year-old white female who presented with the complaint of dysphagia worsening over two to three months. She also reported some history of reflux. The patient underwent EGD, which was normal except for some extrinsic compression of the mid-esophagus. She had a CT

scan that showed an esophageal mass in the upper mid-esophagus. A subsequent barium swallow revealed a smooth 3 cm lesion based on the left lateral aspect of the esophagus. Because of the classic appearance, it was presumed to be a leiomyoma.

Due to her symptoms, the decision was made to proceed with surgical removal of the mass. With the left-sided location, there was concern about the ease of removal if a right-sided approach was used. The concern about a leftward approach was the involved anatomy; namely, the bronchus and aorta. After consideration, the decision was made to perform a left thoracotomy.

### Procedure

The patient was intubated using a double lumen endotracheal tube using fiberoptic bronchoscopy to ensure correct placement. She was then placed in the left lateral position. The fifth rib was then resected in the subperiosteal plane. The left lung was then deflated with the subsequent natural separation of the space between the bronchus and aorta. The bulging leiomyoma was then easily visually identified. Her mediastinal pleura was then divided over the mass. The leiomyoma was easily enucleated using both blunt and sharp dissection without damage to the mucosa. Because the dissection went so smoothly and the mucosa was obviously intact, the esophageal lumen was not injected with dye.

The muscular layer was then reapproximated and a





*HEALTH  
DATA  
SERVICES,  
LLC*

*a medical information  
management company*

An independent medical  
transcription company  
providing services  
to small practices,  
large clinics, and  
hospital overflow  
throughout Arkansas.

### **DO YOU SUFFER FROM TRANSCRIPTION OVERLOAD?**

350 Salem Road, Suite 6C • Conway, AR 72032  
Phone: (501) 327-7077 • Fax: (501) 327-8588  
Email: [hdsllc@cyberback.com](mailto:hdsllc@cyberback.com)

## For the Investments of your Life...



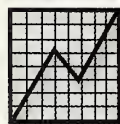
**I**NVESTING is not "The End." Investing is "The Means."  
The desired end is reached by planning, growing and  
finishing well. Our expertise is implementing investment  
strategies that best empower *your* plans for growing and  
finishing well.

Clients include individuals, retirement plans, trusts and  
foundations. All enjoy a competitive fee-only service.  
We can add value and peace of mind to the investments  
of *your* life.

(Left to Right): Bill Smith, Keith McCullough,  
Jim Strawn and Stephen Chaffin.



**THE BEST CHOICE IS AN INDEPENDENT INVESTMENT ADVISOR**



**SMITH  
CAPITAL  
MANAGEMENT**

Pleasant Valley Office Center  
12115 Hinson Road  
Little Rock, AR 72212  
501/228-0040 or 800/866-2615  
fax 501/228-0047

pleural flap was performed for reinforcement and coverage. A chest tube was then placed. The patient was extubated and taken to the recovery room in stable condition. She was placed in the ICU overnight and transferred to the floor the next day. She progressed well and was able to eat a regular diet and was discharged home on the fourth postoperative day.

A frozen section was not obtained intraoperatively because the tumor was relatively small and had the characteristic features of a leiomyoma. The literature does suggest that large tumors go for frozen section. Her final pathology report revealed a 3.1-by-2.2-by-1.6 cm benign leiomyoma.

### **Discussion**

Leiomyomata are the most common benign tumors of the esophagus, making up 80% of the benign tumors of the esophagus.<sup>3</sup> According to one study, the mean longitudinal size in adults is 4.9 cm.<sup>5</sup> The average patient age is 38 years. Ninety percent of the tumors found in the lower two-thirds of the esophagus. They are twice as common in males. The origin is smooth muscle, and the tumors are usually oval in appearance. They are solitary and encapsulated. The accepted workup includes barium swallow, CT and EGD. A biopsy during EGD is not recommended because in the case of leiomyoma, successful enucleation without esophageal resection is dependent upon mucosal integrity. Recently, endoscopic ultrasound has been suggested as a useful tool for evaluating these tumors.<sup>5,6</sup> Surgery is recommended when these tumors are discovered, especially when symptomatic, because of the progressive nature of the symptoms. A right- vs. left-sided approach depends on tumor location. Open thoracotomy versus thoracoscopy should be considered, depending on tumor size and location. One study suggested that inserting an esophageal balloon intraoperatively aided enucleation.<sup>6</sup>

In this case, a left thoracotomy was chosen because of concern for adequate exposure at the mid-upper esophageal location of the leiomyoma. In

retrospect, this could easily have been performed thoracoscopically, even up to the level of the aortic arch, because the airway is easily displaced forward with desulfation of the lung. In the past, a right approach has been suggested for middle to upper esophageal leiomyomata, whether on the right or left esophageal wall.

Presumably, this is due to anatomical concerns. However, as is demonstrated in this case, with desulfation of the lung, the bronchus is easily displaced forward and a leftward approach can be safely performed up to the aortic arch. ■

*Dr. Davis is a third-year family practice resident at AHEC Northeast in Jonesboro, where Drs. Rusher, Phillips and Wiggins are staff surgeons at St. Bernards Regional Medical Center.*

#### Bibliography

1. Schwartz. Principles of Surgery, McGraw Hill, 1994.
2. Bonavina L, Segalin A, Rosati R, Pavanello M, and Peracchia A: Surgical therapy of esophageal leiomyoma. Journal of the American College of Surgeons, Sept. 1995, Vol. 181, pp. 257-262.
3. Bardini R, Asolati M: Thoracoscopic resection of benign tumors of the esophagus. International Surgery, 1997; 82:5-6.
4. Taniguchi E, Kamiike W, Iwase K, Nishida T, Akashi A, Ohashi S, and Matsuda H: Thoracoscopic enucleation of a large leiomyoma located on the left side of the esophageal wall. Surgical Endoscopy, 1997; 11:280-282.
5. Watanabe M, Kuwano H, Sadanaga N, Ikebe M, Mori M, and Sugimachi K: Leiomyoma of the esophagus with special reference to the characteristics of this tumor in teenagers. Hepato-Gastroenterology 44, 1997, pp. 164-169.
6. Mafune K, Tanaka Y: Thoracoscopic enucleation of an esophageal leiomyoma with balloon dilator assistance." Surgery Today, 1997. Vol. 27, pp. 189-192.

## ARCHITECTURE

FOR YOUR MEDICAL NEEDS

1 800 764 ASTI

William Henry Asti, AIA

architects, economists, development consultants

## ST. VINCENT HEALTH SYSTEM

### Hospitalist Opportunity

Actively searching for internist interested in serving in the exciting new specialty of full time hospital care. If you have a interest or know someone interested in a hospitalist role, please contact Faye G. Stewart at St. Vincent Health System 501-660-3245 or 800-482-1288 ext. 3245.

+ CATHOLIC HEALTH INITIATIVES

### St. Vincent Health System

INTENSIVE CARING.

[www.stvincenthealth.com](http://www.stvincenthealth.com)

Doctors Complex with over 275,000 square feet of Class A Medical Office space is conveniently located in the heart of Little Rock's Medical Corridor and within a three mile radius of St. Vincent Infirmary, UAMS, Baptist Medical Center, Little Rock's VA Hospital, Arkansas Childrens' Hospital and adjacent to St. Vincent Doctors Hospital.

**LRMA**

DOCTORS BUILDING - DOCTORS PLAZA

SUITES

AVAILABLE

FROM

496 SQUARE FEET

TO

2436 SQUARE FEET

#### LEASING INFORMATION:

Betty Garcia Little Rock Medical Associates

Phone: 501-664-1812

Fax: 501-664-9212

E-mail: [egarcia@lrma.com](mailto:egarcia@lrma.com)



# Endovascular Repair of Abdominal Aortic Aneurysms

Michael F. Knox, MD, FACR, — Fred A. Meadors, MD

*In September 1999, the Food and Drug Administration approved two devices for the endovascular repair of abdominal aortic aneurysms. The endografts are placed from within the arteries using fluoroscopic guidance. The minimally invasive technique is performed using bilateral femoral artery cut-downs and has significant advantages over open surgical repair, including a reduction in morbidity, hospital stay and blood loss, with a much quicker return to normal activities. Endoleaks are the main complication following endovascular repair, and close follow-up of patients with CT is recommended to confirm adequate exclusion of the aneurysm.*

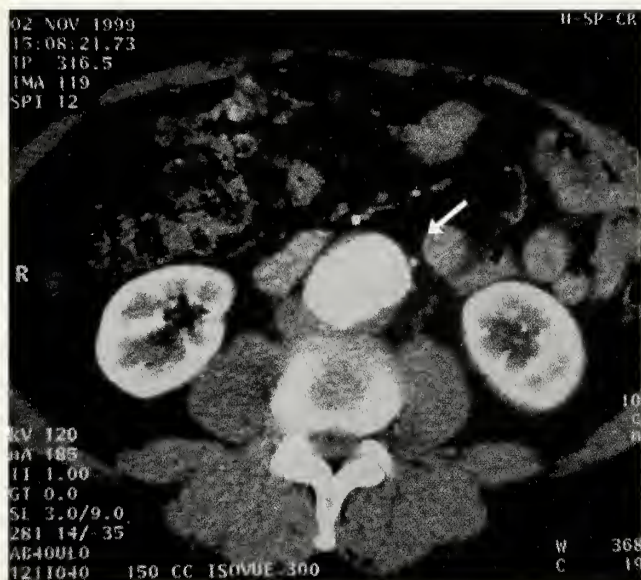


Fig. 1. Spiral CT scan shows a 4.7 cm infrarenal AAA (arrow).



Fig. 2. 3 cm right common iliac artery aneurysm (arrow).

## Introduction

The prevalence of abdominal aortic aneurysm (AAA) is estimated to have tripled over the last 30 years,<sup>1</sup> and there are approximately 1.5 million Americans with an AAA. About 190,000 new cases are diagnosed annually, and 45,000 undergo surgical repair each year in the United States. It is estimated that 15,000 Americans die each year of AAA rupture, making it the 13th leading cause of death in the United States overall and the 10th leading cause of death in American males.

It is known that the five-year risk of rupture is only 2% if an aneurysm measures less than 4 cm in diameter, but the five-year risk increases to 25-41% if the aneurysm is greater than 5 cm in diameter. On average, aneurysms tend to enlarge by 0.5 cm per year.<sup>1</sup>

Most AAA's occur in patients older than 55, and there is a strong male predominance. Significant risk factors include a family history of aneurysms, generalized atherosclerosis, advanced age, hypertension and cigarette smoking.

Although most aneurysms are asymptomatic, some may present as a pulsatile mass or may cause pain. AAA's are usually diagnosed on routine physical exam but are also discovered fortuitously on ultrasound, CT, MRI or arteriography done for other reasons.

## AAA Treatment

Since the 1950s, surgical management of AAA's has been the treatment of choice; however, mortality rates of up to 7.3% and significant morbidity in 15-30% of surgically treated patients has prompted investigators to develop a less invasive approach in the treatment of AAA's.<sup>2</sup> In



1991, Parodi presented his experience with a homemade stent graft device constructed from large Palmaz stents and fabric, used to successfully exclude AAA's in five patients.<sup>3</sup>

Since that time, other investigators have worked with different endograft designs, and worldwide experience with the different devices is accumulating rapidly. The terms "endovascular" and "endograft" refer to grafts implanted from within the blood vessels via minimally invasive techniques using X-ray imaging guidance. The endografts are contained within delivery catheters and are deployed into position using catheter and guidewire techniques. Instead of being sewn into position as in an open repair, the endografts are anchored by stents and/or hooks. They also are usually balloon-dilated to secure fixation and apposition to the native arterial wall.

In September 1999, the FDA approved two endovascular devices for clinical use in the repair of AAA's: ANCURE (Guidant Cardiac & Vascular Surgery Group, Menlo Park, Calif.) and AneuRx (Medtronic/AVE, Sunnyvale, Calif.). There are at least seven other endograft devices in clinical trials in the United States. At St. Vincent Infirmary Medical Center in Little Rock, we have developed an endovascular program and have gained early experience with the bifurcated ANCURE Endograft in our patients.

### Endovascular Repair

The prime objective of endovascular repair of AAA's is the same as in surgical repair, i.e. to eliminate the risk of aortic rupture by sealing, or excluding, the aneurysm from aortic blood flow. Secondary objectives include reduction in aneurysm size, reduction in patient morbidity and mortality, reduction in patient discomfort and recovery periods, a decrease in blood loss and the need for transfusion and lowering of cost. To make endovascular repair a viable alternative to surgical repair, durable results must be achieved.

Patient selection for endovascular repair is critical to achieving good outcomes. The primary diagnostic study is a contrast-enhanced spiral or helical CT scan of the entire abdominal aorta and iliac arteries. Nonionic contrast media of 150 ml are infused via an 18- or 20-gauge IV in an antecubital vein at 3-4 ml per second. Spiral/helical CT acquisition is done from the celiac artery to the femoral bifurcations using 3 mm collimation at a pitch of 2-1 or 3-1. The images are reconstructed at a 1.5 mm slice thickness.

Also obtained are 2D coronal and sagittal computer-reconstructed images and 3D maximum-intensity projection and shaded surface display reconstructions.

Careful measurements are made, and key features required for the ANCURE Endograft include an infrarenal neck of a diameter no greater than 26 mm, which is at least 10-15 mm in length.

Care should be taken to avoid superior necks with intraluminal thrombus or extensive calcification. For the bifurcated endograft, the iliac "landing zones" must be less than 14 mm in diameter and at least 20 mm in length. The presence

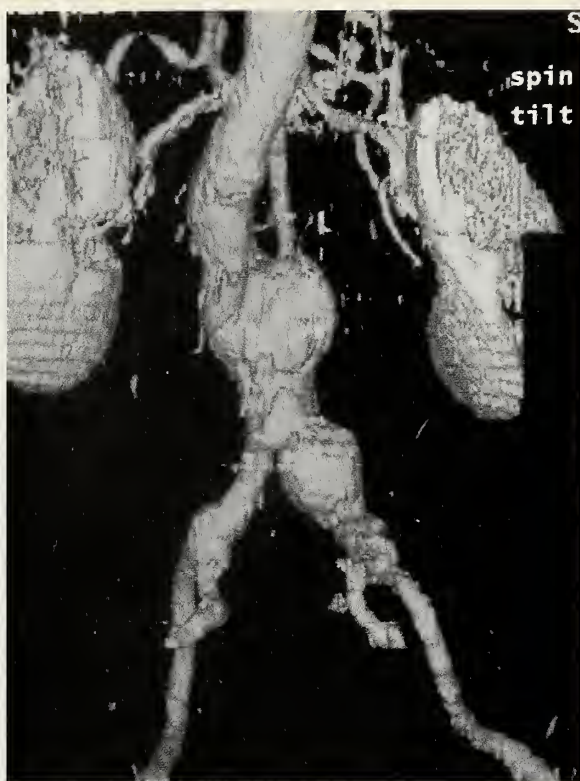


Fig. 3. Shaded surface display (SSD) reconstruction of contrast-enhanced spiral CT (posterior view).



Fig. 4. Intraoperative aortogram with the Angioscale Catheter (lower arrow) shows AAA (upper arrow) and right common iliac artery aneurysm (middle arrow).



of excessive tortuosity and dense calcification may be relative contraindications to endograft placement.

The femoral and iliac access arteries must be able to accept the 24 French ipsilateral expandable sheath and a 12 French contralateral sheath to allow successful graft delivery.

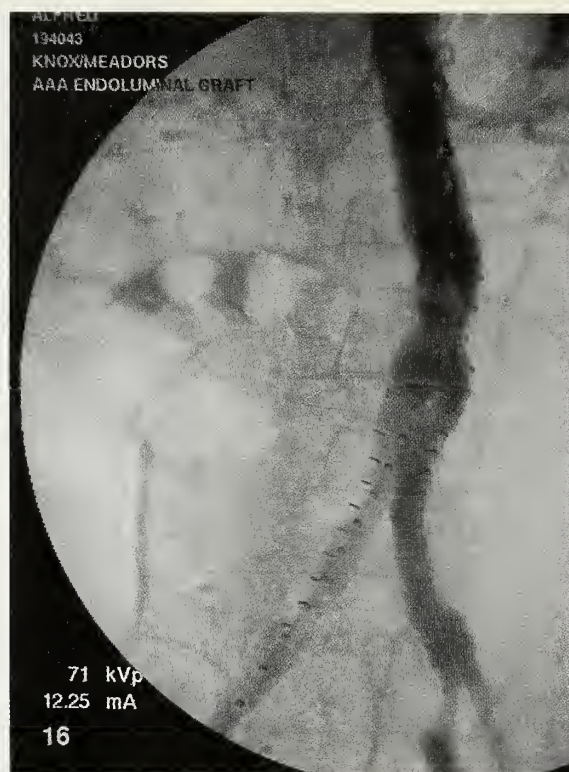
Before endovascular repair, a marker catheter arteriogram is done with the Angioscale Catheter (Guidant, Menlo Park, Calif.). This is especially useful for judging the length of the endograft to be deployed and confirming diameter measurements.

Occasionally, preoperative embolization of large branch arteries, such as accessory renal, inferior mesenteric, lumbar or internal iliac arteries, may be performed. This may, in some cases, decrease the occurrence of retrograde flow of blood into the excluded aneurysm sac, a complication that is known as an endoleak.<sup>4</sup> As with any surgical procedure, patients are carefully evaluated for cardiovascular, respiratory and hematologic risk factors.

Patients for endovascular repair of AAA's are prepared similarly to those undergoing open repair, i.e. NPO before the procedure, bowel prep and prophylactic antibiotics. Although most endovascular repairs are done using general anesthesia, some endovascular physicians have used epidural or local anesthesia with conscious sedation.

Endovascular repair with the ANCURE Endograft is done using bilateral femoral cut-downs and arteriotomies. A 24 French expandable sheath is placed via the ipsilateral femoral arteriotomy and a 12 French sheath is placed in the contralateral femoral artery. The ANCURE Endograft is contained within a 23.5 French delivery catheter and is placed through the ipsilateral sheath into the infrarenal aorta, with positioning monitored by intraoperative fluoroscopy and arteriography. The contralateral limb of the graft is snared via the contralateral sheath and brought into appropriate position within the iliac artery. Both proximal and distal attachments are anchored with stents and hooks, which are secured in place with balloon dilatation.

The body of the graft is constructed of woven polyester similar to routine aortic graft material. One unique feature of the ANCURE Endograft is its bifurcated unibody design (one piece of fabric), which is constructed with stents at the proximal and distal attachment zones but is unsupported



**Fig. 5.** Completion of the intraoperative aortogram shows complete exclusion of the aneurysms with the ANCURE Endograft.

throughout the body and limbs of the graft. This design may decrease the incidence of late complications (i.e. endoleak or limb kinking/occlusion) since it is flexible and able to conform to changes in the size and shape of the aneurysm sac that are known to occur with time.<sup>5</sup>

## Case Presentation

A.E. is a 68-year-old man with no significant past medical problems, who was noted to have an AAA on routine physical examination. His father had also had a large AAA that required emergent repair about 40 years ago. An ultrasound of the abdomen confirmed a 4.7 cm infrarenal AAA, and a subsequent contrast-enhanced spiral CT scan delineated the AAA (Fig. 1), as well as a 3 cm right common iliac artery aneurysm

(Fig. 2). Measurements taken included a 25 mm diameter infrarenal neck extending about 5 cm in length. To assess the configuration of the aneurysms and perform length measurements allowing selection of the appropriate-size ANCURE Endocraft, 2D and 3D CT reconstructions (Fig. 3) were done. Confirmatory measurements were made with a marker catheter arteriogram.

Because the right common iliac aneurysm was noted to extend close to the origin of the internal iliac artery, embolization of the internal iliac artery was performed using Gianturco coils (Cook Inc.) (Fig. 4). This was done to allow extension of the ipsilateral graft limb over the origin of the internal iliac artery to completely exclude the common iliac aneurysm and prevent an endoleak.

One week following the arteriogram and internal iliac artery embolization, the patient underwent placement of an ANCURE Endograft in the operating room at St. Vincent Infirmary Medical Center. The procedure was done under general anesthesia using bilateral femoral arteriotomies. A 26 mm diameter, 16 cm long ANCURE Endograft was placed under fluoroscopic guidance.

Completion arteriography in the operating room showed complete exclusion of both the abdominal aortic aneurysm and the right common iliac aneurysm without evidence for endoleak or limb stenosis (Fig. 5).

The patient was able to be ambulatory that evening and resumed a regular diet. He was discharged the following morning without complications. A follow-up CT scan at



one week showed thrombosis of the aneurysm sac around the endograft with successful exclusion of both the AAA (Fig. 6) and the right common iliac aneurysm (Fig. 7). There was no evidence of an endoleak or other complication. The patient was able to resume his normal activities within 10 days, including playing a round of golf.

## Discussion

Our patient highlights some of the major advantages of endovascular repair. Experience has shown lower morbidity, less blood loss, shorter hospital stays and recovery time, and a quicker return to normal activities with endovascular repair as compared to conventional surgical repair.<sup>6</sup>

Successful exclusion of aneurysms using endografts is achieved in a high percentage of patients, with Jacobowitz et al. reporting only 3% of 669 patients undergoing emergent explantation and surgical conversion and 4% requiring late elective conversion because of persistent endoleak, migration or enlargement of the aneurysm.<sup>7</sup>

These data were collected from patients receiving the early EVT endograft as well as ANCURE, and improved success rates are expected with the improved ANCURE Endograft. In high-risk patients, endovascular repair is also safe and effective and may be considered the preferred method of treatment.<sup>8</sup> Patient acceptance is very favorable as post-procedure discomfort is mild and there is such a short down time for patients with this minimally invasive repair.

At present, the cost of the available devices offsets the savings generated by shorter hospital stays and reduced morbidities, making the cost of endovascular repair very



Fig. 6. A one-week postoperative CT scan shows thrombosis of the aortic aneurysm sac (arrow) around the enhanced limbs of the ANCURE Endograft.

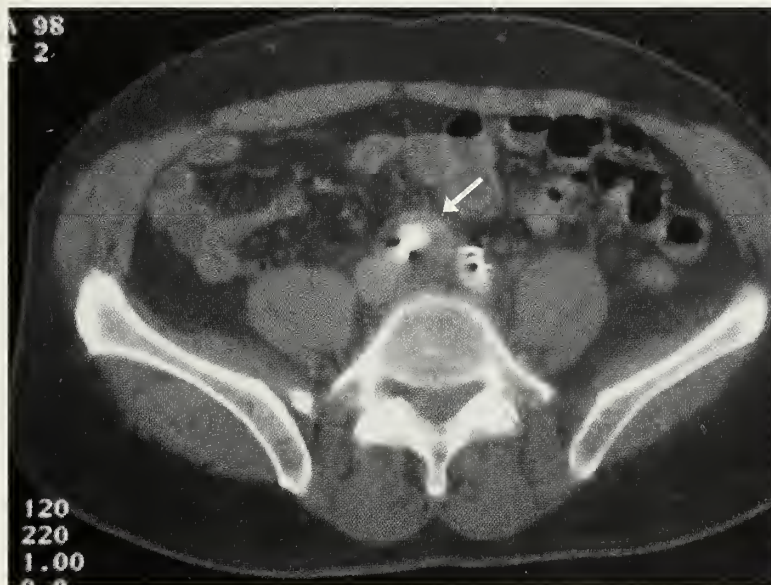


Fig. 7. Lower image from the postoperative CT shows thrombosis of the right common iliac artery aneurysm (arrow) around the right limb of the Endograft.

similar to open repair. It is thought that as more devices are approved for clinical use, prices will decrease, making endovascular repair more cost-effective than open repair and more appealing to hospitals' financial analyses.

Not all patients with AAA's are candidates for endovascular repair, however, and careful screening is required with CT and arteriography. With the currently available endovascular devices, 40-75% of patients may be amenable to endovascular repair. The average normal diameter of the abdominal aorta in women is approximately 1.8 cm and, in men, 2.2 cm. Most physicians consider treatment of an AAA as it approaches a diameter of twice normal. In general, once an AAA reaches 4.5-5.0 cm diameter, surgical repair is usually recommended.

There is debate among endovascular physicians whether the threshold for endovascular

repair should be lowered. There are those who believe that since the endovascular repair of smaller aneurysms is frequently technically simpler than with larger aneurysms, and that more patients may be suitable candidates (because of less expansion to involve the juxtarenal segment of aorta and less tortuosity and angulation of the aortic neck and iliac arteries), endovascular repair should be recommended for patients at an earlier stage.

It has been hypothesized by some investigators that the incidence of late complications may be less after endovascular repair of smaller aneurysms, since there will be a proportionately smaller change in size and configuration of the aneurysm sac. This question is being debated, and further study will be required before a consensus is



reached on the appropriate threshold for endovascular repair.

## Complications

The failure of an endograft to completely exclude an aneurysm from arterial blood flow is called an endoleak. This continued blood flow into the aneurysm sac around the endograft is best diagnosed by contrast-enhanced spiral/helical CT. White et al. developed a classification system for endoleaks, with Type I referring to

**If the aneurysm is seen to be shrinking despite an endoleak, no intervention is generally felt to be necessary, but if there is expansion of the aneurysm, correction of the endoleak is required.**

leaks at the proximal or distal attachment zones due to incomplete seal, Type II representing flow to the aneurysm sac via branch arteries<sup>9</sup>, Type III caused by defects in the graft material or modular disconnection, and Type IV being graft porosity.<sup>10</sup>

The most common type of leak is a Type II leak, but the significance of these is not clearly understood. Early Type II endoleaks are common and may occur in up

to 40% of patients following endovascular repair.<sup>4,9,10</sup> The majority of these will resolve spontaneously without intervention, but most endovascular physicians feel that careful follow-up with CT is important.

There have been reported cases of aneurysm rupture following endovascular repair, complicated by a persistent endoleak. If the aneurysm is seen to be shrinking despite an endoleak, no intervention is generally felt to be necessary, but if there is expansion of the aneurysm, correction of the endoleak is required.

Type I endoleaks can usually be

resolved by angioplasty and/or stenting of the attachment zone leak. In Type II leaks, careful arteriography is required to identify the inflow and outflow branch arteries to the aneurysm sac. Most of these will be amenable to embolization with resolution of the endoleak. Type III leaks are less common but may require additional graft segments or explantation of the endograft and conventional surgical repair. Type IV leaks are seen with some of the graft materials but have not been reported with the ANCURE Endograft. When they occur, Type IV leaks are almost always transient, requiring no intervention.

Other serious complications of endovascular repair are uncommon but include arterial trauma with rupture, dissection or occlusion, wound infection; blue toe syndrome from distal embolization; myocardial infarction; and acute renal failure. As with traditional surgical grafts, limb stenosis or occlusion may occur, which could require thrombolysis, angioplasty, stenting or surgical revision. Pyrexia following endograft placement is fairly common but is thought to be of no significance.

## Conclusions

Endovascular repair is an exciting new minimally invasive treatment option for some patients with AAA's. Careful screening with contrast-enhanced CT and arteriography is necessary to identify patients who are appropriate candidates. Endovascular repair compares favorably with open repair in the protection from rupture but is associated with less morbidity, shorter hospital stays and recovery time, and less pain. Post-implantation follow-up CT scans are required to assess for endoleak, and some patients may require further intervention.

*Dr. Knox is a physician with Radiology Associates PA in Little Rock. Dr. Meadors is a physician with Cardiovascular Surgeons PA in Little Rock.*

## Bibliography

1. Zarins CK, Harris J. Operative repair for aortic aneurysms: The gold standard. *J Endovasc Surg* 1997; 4:232-241.
2. Zarins CK, et al: AneuRx stent graft versus open surgical repair of abdominal aortic aneurysms: Multicenter prospective clinical trial. *J Vasc Surg* 1999; 29:292-308.
3. Parodi JC, Palmaz JC, Barone HD. Transfemoral intraluminal graft implantation for abdominal aortic aneurysms. *Ann Vasc Surg* 1991; 5:491-499.
4. White GH, Yu W, May J et al: Endoleak as a complication of endoluminal grafting of abdominal aortic aneurysms: Classification, incidence, diagnosis, and management. *J Endovasc Surg* 1997; 4:152-168.
5. Harris P, et al: Longitudinal aneurysm shrinkage following endovascular aortic aneurysm repair. *J Endovasc Surg* 1999; 6:11-16.
6. May J, et al: Concurrent comparison of endoluminal versus open repair in the treatment of abdominal aortic aneurysms: Analysis of 303 patients by life table method. *J Vasc Surg* 1998; 27:213-221.
7. Jacobowitz GR, Lee AM, and Riles TS, for the EVT Investigators. Immediate and late explantation of endovascular aortic grafts: The Endovascular Technologies experience. *J Vasc Surg* 1999; 29:309-316.
8. Chuter TAM, et al: Endovascular aneurysm repair in high-risk patients. *J Vasc Surg* 2000; 31:122-133.
9. White GH, May J, Waugh RL, et al: Type I and Type II endoleak: A more useful classification for reporting results of endoluminal AAA repair. (Letter) *J Endovasc Surg* 1998; 5:189-191.
10. White GH, et al: Type III and Type IV endoleak: toward a complete definition of blood flow in the sac after endoluminal AAA repair. *J Endovasc Surg* 1998; 5:305-309.

# PEOPLE+EVENTS

## HONORED

### Physician, Entrepreneur Receives Distinguished Service Award

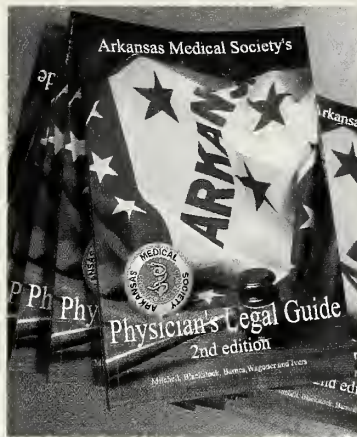
Dr. Paul I. Wills of Fort Smith received the Distinguished Service Award from the American Academy of Otolaryngology—Head and Neck Surgery on Sept. 24.

The award was presented to Dr. Wills during the opening ceremony of the Academy of Foundation Annual Meeting/Oto Expo in Washington, D.C., in recognition of his many years of service to the Academy. Dr. Wills served as secretary and chair of the board and governors and is a member of several committees. He also has served on the editorial board of the American Journal of Otolaryngology.

Dr. Wills was honored as Businessman of the Year in 1999 by the National Republican Congressional Committee. It was one of six awards distributed across the country to the top business leaders who have been instrumental in helping to reform the Internal Revenue Service, pass the Financial Freedom Act of 1999 and maintain a Republican majority in Congress.

Dr. Wills is in private practice at the Otolaryngology—Head and Neck Surgery Division of Cooper Clinic in Fort Smith and has established Wills Labs, a nutritional supplement company based in Hewitt, Texas.

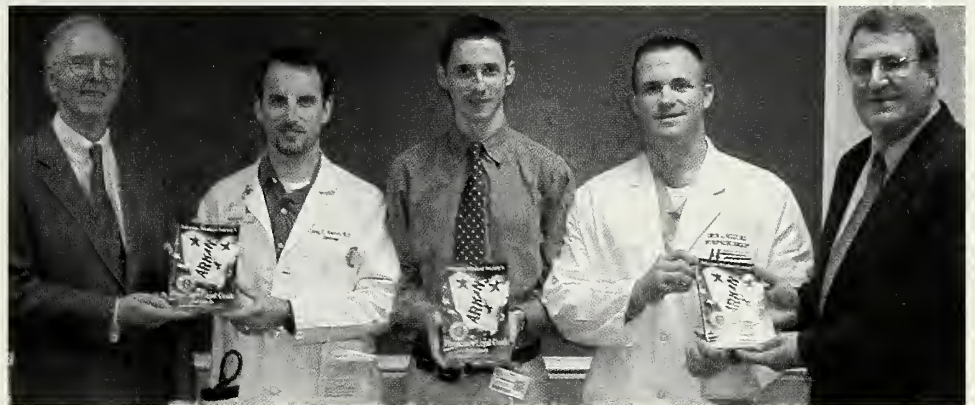
He is a graduate of



### Legal Guides Put to Use

AMS President Dr. Gerald Stolz and Dr. James Kyser recently delivered 525 copies of the AMS' *Physician's Legal Guide, Second Edition* to residents at the University of Arkansas for Medical Sciences.

The gift was a joint effort of the AMS and the Medical Education Foundation for Arkansas, the medical Society's educational foundation. Dr. Jeanne Heard, associate dean for graduate medical education, submitted a grant request to MEFFA last spring expressing the need for residents—especially those in their last year of training—to be aware of laws and regulations affecting the practice of medicine.



AMS' new legal guides are presented to UAMS residents. Left to right, Dr. James Kyser, Dr. Joseph Keuter, Dr. Larry Markham, Dr. Owen Kelly and Dr. Gerald Stolz, AMS president.

Baylor College of Medicine in Houston. He completed residencies in Arizona and Houston and a two-year term with the U.S. Air Force.

### Physicians Receive Awards from AMA

Each month the American Medical Association presents the Physician's Recognition Award to those who have completed acceptable programs of continuing education.

AMA recipients for June include Drs. Lori Beth Bacon, Anton L. Duke and Brian M. Kubacak, all of Little Rock; Drs. Elisa M. Payne and Timothy L.

Spradlin, both of Fort Smith; Dr. Jody Warren Peebles of North Little Rock; Dr. James R. Arnold of Jonesboro; Dr. Donald L. Cohagan of Bentonville; Dr. Joseph A. Cook of Conway; Dr. John S. Elkins of Arkadelphia; Dr. Michael C. Hendren of Russellville; Dr. Jose S. Padilla of Harrison; Dr. Harry D. Starnes of Clinton; Dr. Joe M. Tullis of Mountain Home; Dr. Richard D. Tutt of Springdale; and Dr. Bruce A. White of Malvern.

AMA recipients for July include Drs. James D. Billie, Gunnar H. Gibson and William Q. Sturner, all

of Little Rock; Drs. John C. Dobbs and Jimmie J. Magie, both of Conway; Drs. William W. Galloway of Russellville; Dr. John D. Ginger of Fayetteville; and Dr. Morton C. Wilson of Fort Smith.

AMA recipients for August include Dr. Russell B. Allison of Russellville, Dr. Charles W. Logan of Little Rock and Dr. Jane Scott of Sherwood.

AMA recipients for September include Dr. Robert C. Power of Little Rock, Dr. Ronald E. Revard of Harrison, Dr. Rheeta M. Stecker of Hot Springs and Dr. Robert C. Thompson of Van Buren. ■



# New Members

**Tammy G. Albrecht, MD**  
Specialty: FP  
207 Carter St.  
Berryville, AR 72616  
(870) 423-6661

**Fareeda Ann Al-Refai, MD**  
Specialty: R  
P.O. Box 1269  
Fort Smith, AR 72902  
(501) 494-0500

**Clarence J. Arendall, MD**  
Specialty: Resident-FP  
2907 E. Joyce Blvd.  
Fayetteville, AR 72703  
(501) 521-8260

**Michelle S. Banning, MD**  
Specialty: FP  
P.O. Box 220  
Danville, AR 72833  
(501) 495-7300

**Bing X. Behrens, MD**  
Specialty: N  
311 E. Matthews  
Jonesboro, AR 72401  
(870) 935-4150

**Michael F. Berry, MD**  
Specialty: R  
302 N. 8th St., #3  
Rogers, AR 72756  
(501) 621-6033

**Terry Mac Brown, DO**  
Specialty: FP  
P.O. Box 699  
Judsonia, AR 72081  
(501) 729-3114

**Shannon H. Brownfield, MD**  
Specialty: Resident-FP  
2907 E. Joyce Blvd.  
Fayetteville, AR 72703  
(501) 521-8260

**Aris Calhoun, MD**  
Specialty: FP  
1500 McLain St.  
Newport, AR 72112  
(870) 523-9337

**Stephen M. Chatelain, MD**  
Specialty: OBG  
9601 Lile Drive, # 850  
Little Rock, AR 72205  
(501) 217-8467

**Vera Y. Collins, MD**  
Specialty: Resident-FP  
612 S. 12th St.  
Fort Smith, AR 71901  
(501) 785-2431

**James B. Cotner, MD**  
Specialty: FP  
25 Professional Park Drive  
Clarksville, AR 72830  
(870) 862-2489

**Robert M. Cowherd, MD**  
Specialty: Resident-FP  
4010 Mulberry St.  
Pine Bluff, AR 71603  
(870) 541-6010

**Paul E. Daidone, MD**  
Specialty: IM  
200 S. Moose St.  
Morrilton, AR 72110  
(501) 354-4637

**Bruce A. Darrow, MD**  
Specialty: OB  
2010 Chestnut, #B  
Van Buren, AR 72956  
(501) 410-1966

**Richard K. Davis Jr., MD**  
Specialty: Resident-FP  
460 W. Oak St.  
El Dorado, AR 71730  
(870) 862-2489

**Orrin J. Davis, MD**  
Specialty: Resident-PD  
800 Marshall St.  
Little Rock, AR 72202  
(501) 320-1875

**Justin D. Dawson, MD**  
Specialty: Resident-FP  
223 E. Jackson  
Jonesboro, AR 72401  
(870) 972-0063

**Alberto Dominguez-Ventura, MD**  
Specialty: Resident-GS  
4301 W. Markham St., #520  
Little Rock, AR 72205  
(501) 405-1952

**Anton L. Duke, MD**  
Specialty: PD  
500 S. University Ave., #200  
Little Rock, AR 72205  
(501) 661-0308

**Delilah L. Easom, MD**  
Specialty: Resident-IM  
4301 W. Markham St.  
Little Rock, AR 72204  
(501) 686-5162

**Frank D. Edwards, MD**  
Specialty: FP  
101 Hospital Drive  
Magnolia, AR 71753  
(870) 235-3000

**Bobby T. Enslinger, MD**  
Specialty: Resident-FP  
612 S. 12th St.  
Fort Smith, AR 72901  
(501) 785-2431

**Etiya M. Farooq, MD**  
Specialty: Resident-FP  
4301 W. Markham St.  
Little Rock, AR 72205  
(501) 686-6560

**Ronnie M. Fenton, MD**  
Specialty: R  
500 S. University Ave., #108  
Little Rock, AR 72205  
(501) 664-3914

**Christine M. Finck, MD**  
Specialty: Resident-GS  
800 Marshall St.  
Little Rock, AR 72203  
(501) 320-1446

**Regina P. Foley, MD**  
Specialty: Resident-FP  
4010 S. Mulberry St.  
Pine Bluff, AR 71603  
(870) 541-6010

**Sean M. Foley, MD**  
Specialty: Resident-PM  
4301 W. Markham St.  
Little Rock, AR 72205  
(501) 686-5444 ■

## LETTER *Continued from page 232*

before on clinical income for survival. Likewise, most of the residents are going into private practice and can profit greatly from your experience in that field. The rewards in academics must be measured by standards other than total financial gain, however. It is true that incomes are much lower, but I contend that the rewards are much higher. Not only are the residents often appreciative of your hard-won practical insights, but there is a chance to change the actual practice of medicine for the better through areas of either basic or clinical research. It is immensely satisfying to see some paper on which I spent a year's effort referenced in the literature, or hear a resident mention its message. That ranks right up there with doing a clinical

case of importance and difficulty in the special procedures room and caring for that patient and family, previously my greatest professional pleasure. Research and teaching may actually have more positive impact on the big picture of health care than anything else I can do. It can be very good indeed.

I see others who are fed up with the greed, pettiness, and red tape that now constitutes so much of medical care, turn away from a true calling to an early retirement of no substance. We were all trained to do things of substance. We are good at it. We need it. We should not turn to the life of the dilettante. Instead, I would suggest an alternative which, though far from perfect and occasionally burdened with pointless hassles, may be a good fit for some

individuals. Give academics a try. The need for faculty is acute in many areas. This can take advantage of your lifetime of work and training, allow you to give back to the community in ways you never anticipated, and, most of all, may provide that satisfaction which all of us need in our lives. Do it for the future of medicine. Do it for yourself. ■

*Sincerely,*

*William C. Culp, MD*  
Assistant Professor  
Chief, Section of Vascular and  
Interventional Radiology  
Department of Radiology  
University of Nebraska Medical Center



## Mountain Harbor Resort

Mountain Harbor Resort is Lake Ouachita's premier resort community.

It is nestled in the quiet coves and forested shorelines of Lake Ouachita, the state's largest man-made lake. This family-owned resort offers warm hospitality, fine accommodations, a full-service marina and a wide array of recreational opportunities.

Guests may spend the night in an airy lodge with rooms that open onto a big lawn overlooking the lake, poolside cabanas, cottages with lake views and hot tubs or beautifully appointed condominiums. All cottages and condos offer fully equipped kitchens, cable television, telephones and native stone fireplaces.

During off-season, from the day after Labor Day through the end of February, prices range from \$55 per night for a lodge room without kitchenette to \$225 per night for a three-bedroom, three-bath unit. In-season prices are \$79.95-\$295 per night. A three-night minimum is required on all holiday weekends. For reservations, call (870) 867-1200.

Nearby Hot Springs touts a variety of restaurants, or guests may dine at the casual resort restaurant, known for its catfish, steaks, burgers, homemade desserts and Southern-style breakfasts. Work off those biscuits and gravy by nature watching, playing

water sports, hiking or horseback riding.

Deer, black bears, wild turkeys and other wildlife live in the Ouachita National Forest, and the lake is a wintering home for eagles. In fact, one of the resort's most popular events is Eagle Extravaganza, an eagle-watching event scheduled for the last week of February.

Lake Ouachita is a popular destination for swimmers, scuba divers, water skiers, sailors and fishermen, and the resort's full-service marina offers pontoon, ski and fishing boats for rent.

Horse lovers should call Mountain Harbor Riding Stables, (870) 867-3022 for a guided trail ride.

The Ouachita Mountains boast 480 miles of nature trails, including the 192-mile Ouachita National Recreation Trail. Detailed trail maps are available from the Mt. Ida Area Chamber of Commerce, (870) 867-2723.

Finally, the resort is a perfect base for a weekend getaway to Hot Springs' Oaklawn Park, which offers thoroughbred racing from February-April.

The resort lies on the southern shore of Lake Ouachita. It is a 30-minute scenic drive from Hot Springs National Park and just 12 miles east of rustic Mt. Ida. Visit [www.mountainharborresort.com](http://www.mountainharborresort.com) for information and driving directions. ■



## ADVERTISERS INDEX

AMS Benefits Inc. ....	Inside back cover
Arkansas Financial Group Inc., The .....	234
Arkansas Foundation for Medical Care .....	Inside front cover
Asti, William Henry, AIA .....	249
Central Flying Service .....	243
EmCare .....	244
Farmers Insurance Group .....	243
Fiser Hummer .....	234
Health Data Services, LLC .....	248
Jefferson Regional Medical Center .....	258
Little Rock Medical Associates .....	249
Maggio Law Firm .....	238
Medical Practice Consultants Inc. ....	242
PhyAmerica Physician Services Inc. ....	240
Regions Bank .....	242
Smith Capital Management .....	248
Snell Prosthetic & Orthotic Laboratory .....	Back cover
St. Vincent Health System .....	249
State Volunteer Mutual Insurance Co. ....	233
University of Arkansas for Medical Sciences .....	244

Special Publications  
Publisher  
*Brigette Williams*

Special Publications  
Editor-in -Chief  
*Natalie Gardner*

Assistant Editor  
*Christy L. Smith*

Copy Editor  
*Donna Schratz*

Sales Manager  
*Stephanie Hopkins*

Account Executives  
*Jason Carson*  
*Liz Earlywine*

Director of Design  
and Circulation  
*Virgeen Healey*

Director of Marketing  
*Allison Pickell*

Production and  
Circulation Coordinator  
*Jeremy Henderson*

Editorial Art Director  
*Irene Forbes*

Advertising Art Director  
*Matt Stewart*

Advertising Coordinator  
*Kristen Heldenbrand*

Marketing Assistant  
*Mitzi Tiffie*

Database Administrator  
*Andrea Martin*

Advertising Assistant  
*Greg Duszota*



**ARKANSAS BUSINESS  
PUBLISHING GROUP**

Chairman & Chief Executive Officer  
*Olivia Farrell*

President and Publisher  
*Jeff Hankins*

Executive Vice President  
*Sheila Palmer*

© 2000 Arkansas Business Publishing Group  
[www.abpg.com](http://www.abpg.com)

## Primary Care Practice Opportunity

**Clinic-based primary care opportunity for Internal Medicine for Cleveland County, Arkansas, a health professional shortage area. Available to applicants with authorization to work. Send CV, with salary requirements and references to Jefferson Regional Medical Center, 1515 West 42nd Avenue, Pine Bluff, AR 71603, ATTN: Sharon Theriot.**

## Doctor of the Day



The Arkansas Medical Society  
needs YOU to participate in the  
Doctor of the Day program, during  
this year's Legislative Session.



To get involved, call Laura Harrison  
at the AMS office, (501) 224-8967  
or (800) 542-1058.



# Arkansas Medical Society Insurance Programs....



## AMS BENEFITS, INC.

A wholly owned subsidiary of the  
Arkansas Medical Society

P.O. Box 55088

Little Rock, Arkansas 72215-5088

(501)224-8967

WATS 1-800-542-1058

FAX (501) 224-6489

"Available products include group  
health, office package, professional  
liability, home, auto, and more."

*tailor-made for physicians*

Insurance products are a fact of life. You can buy them almost anywhere. Fortunately there's one agency that only represents physicians...Arkansas physicians. AMS Benefits, with products to meet both your professional and personal needs.

Call us at 1-800-542-1058 or 501-224-8967



Now Open in Jonesboro

*Pledging commitment is one of the most important things that human beings can do for one another. It means I'll do only my best for you. I'll fight for your rights. I'll be there for you.*

*At Snell Laboratory we make that type of commitment to each of our patients. We dedicate ourselves to making them as comfortable and as mobile as possible. We give them back as much of their former life as we can.*

# A MATCH MADE IN HEAVEN.



*Our computer-aided design and manufacture (CAD/CAM) system makes so much more possible in creating custom-fit prostheses than ever before. And new lightweight, space age materials mean more for our patients with custom orthoses. So regardless of what responsibilities your*

*patients agree to in life, from going out to play to attending a special occasion, our commitment to comfort never waivers.*

*Snell Prosthetic and Orthotic Laboratory has been in business since 1911. We've said "I do" to our patients since day one.*



**SNELL**  
Prosthetic & Orthotic  
Laboratory

THE LATEST IN TECHNOLOGY. THE BEST IN CARE.

Offices located in Little Rock, Russellville, Fort Smith, Mountain Home, Fayetteville, Hot Springs, North Little Rock, and Jonesboro.

Little Rock (501) 664-2624 • Statewide Toll-free 1-800-342-5541

Founding Members of PrimeCare O&P Network - serving the southern United States.



# THE Journal

OF THE ARKANSAS MEDICAL SOCIETY

Vol. 97 No. 8

February 2001

## All in the Family

*Brotherhoods  
of Healing*



MS/HSL  
UNIVERSITY OF MARYLAND AT  
BALTIMORE

JAN 24 2001

REC'D

NOT IN CIRC.

HEALTH SCIENCES LIBRARY  
UNIVERSITY OF MARYLAND  
COLLECTION DEVELOPMENT DEPT.  
601 W LOMBARD ST  
BALTIMORE MD 21201-1512

|||||





In your job every decision is

CRUCIAL

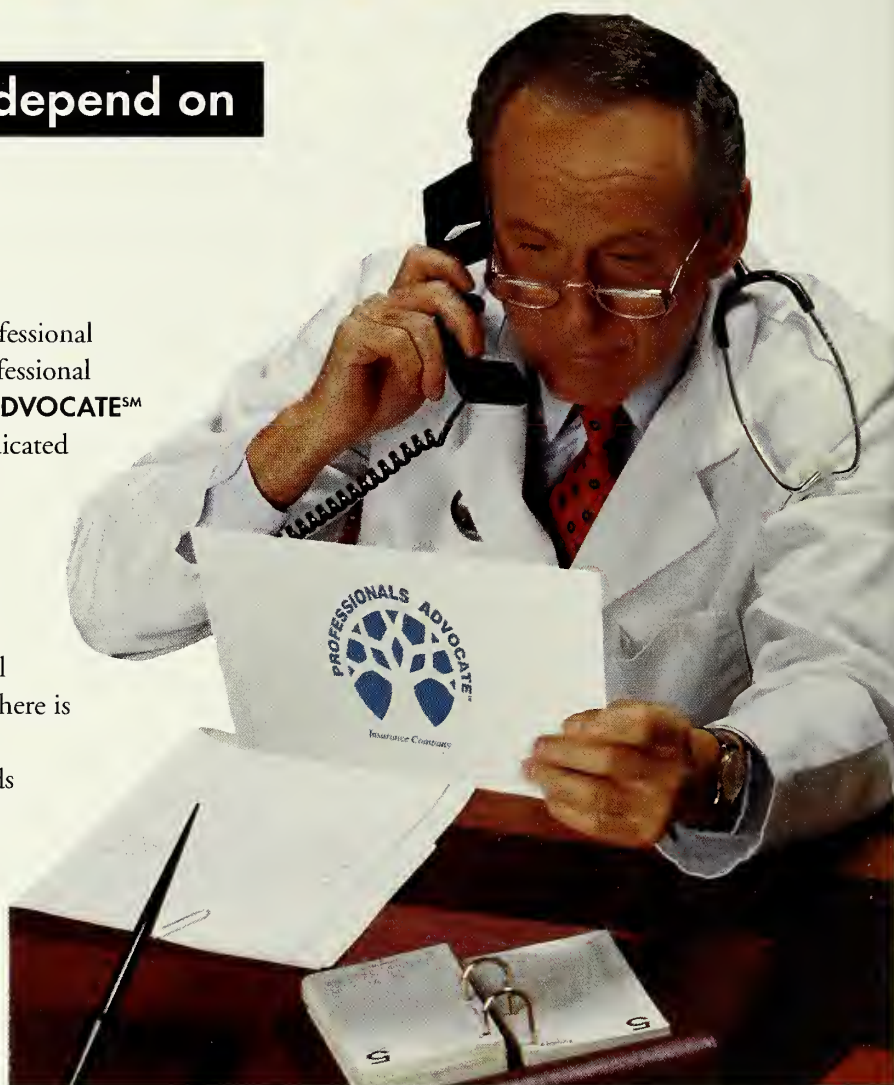
That's why you should depend on

## PROFESSIONALS ADVOCATE<sup>SM</sup>

If you want to make the right choice for your professional liability insurance, start by choosing the right professional liability insurance company. **PROFESSIONALS ADVOCATE<sup>SM</sup> (ProAd)** is a physician-owned liability insurer dedicated to the long-term defense of your career.

**ProAd** was founded by one of the oldest and most respected physician-owned and directed liability insurance companies in the country. This legacy gives us a solid foundation of financial resources, stability and experience. And, because there is direct physician involvement in the decisions that affect you, we are sensitive to the special needs of physicians and have a genuine commitment to protecting your reputation and practice.

Let **ProAd** be your advocate. Call today for additional information and a no-obligation quotation from a **ProAd** Agent conveniently located near you.



## The ProAd Advantage

- Quality coverage for all specialties at competitive prices from a financially stable physician-owned insurer.
- Free Tail coverage upon your full retirement with no age requirement, following one full year of continuous claims-made coverage with **ProAd**.
- Absolute Consent to Settle provision.
- New Practitioner discount.
- Full Prior Acts Coverage available.
- Aggressive claims defense policy. Top local attorneys specializing in medical malpractice defense.
- Defendant's reimbursement coverage. All covered attorney fees and defense-related expenses associated with the investigation paid by **ProAd**.
- Prompt and responsive service.
- Knowledgeable local agents selected for their health care expertise.
- MedGuard Defense Coverage with a limit of \$25,000 for defense of administrative or judicial proceedings included at no additional charge.



*Insurance Company*

**Professionals Advocate<sup>SM</sup>**

[www.weinsuredocs.com](http://www.weinsuredocs.com)

Arkansas Agent: Rebsamen Insurance  
1500 Riverfront Drive, P.O. Box 3198  
Little Rock, AK 72203  
501-661-4800 • 501-666-9592 Fax

Some dealer's waiting list is two years...

Ours is more  
like two  
days.



HONDA S2000

MERCEDES-BENZ S430



At Autoflex Leasing,  
hard to find cars are  
our specialty.

Whether it's a Mercedes S500 or S430, the CLK Cabriolet or all new Honda S2000, your "hard to find" car could be just a phone call away. After all, your patients don't like waiting...Why should you?



**Autoflex**  
L E A S I N G

**1-888-234-1234**





{ PATIENT'S SMILE }

**YOU LOSE A LOT WHEN YOU LOSE YOUR SIGHT. PREVENT DIABETIC BLINDNESS.**  
AFMC encourages Medicare and Medicaid providers to refer their diabetic patients to an eye care professional for an annual dilated eye exam. For more information on the AFMC Health Care Quality Improvement Program, call **1-877-650-AFMC.**



*Arkansas Foundation  
for Medical Care*

# CONTENTS

## FEATURES

### 270 Family Ties

*For some people, medicine is a family affair. Meet two families that have made taking care of people a tradition. The Young family of Texarkana touts nine doctors, while the Jacks brothers of Pine Bluff are looking to groom more doctors in their family.*

### 274 Meet Our Members: Dwight M. Williams, MD

*Dr. Dwight M. Williams credits his brother's childhood accident and his daughter's death for giving him the drive to keep the families of his native Paragould healthy.*

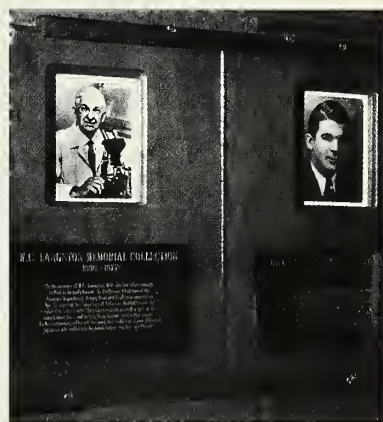
### 283 The Langston Collection

*A plaque and book collection at the University of Arkansas for Medical Sciences honors the lives of Dr. William C. Langston and his son, Bill. The legacy of medicine in the Langston family runs deeper than any plaque can convey, though.*



*Dr. Mitchell Young, with wife Donna, raised 10 children, and eight of their sons became doctors.*

— page 270

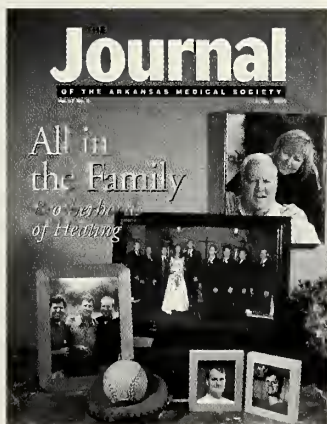


*Medicine runs deep in the Langston family too. A tribute at UAMS honors Dr. William C. Langston and his son, Bill.*

— page 283

## DEPARTMENTS

- 267 Commentary  
Samuel E. Landrum, MD
- 269 What We've Done  
For You Lately
- 277 Loss Prevention
- 280 Cardiology Report
- 282 State Health Watch
- 287 People + Events
- 289 Arkansas Retreats
- 290 Index to Advertisers



*On the cover: The Young family: upper right, Dr. Mitchell and Donna Young; center wedding picture, the Young brothers; lower left, Drs. Chris, Michael and David Young; lower right, Drs. Matthew and Tom Young.*

Cover design: Irene Forbes



# Developing Your Estate Plan?

*Keep These Tips In Mind.*

Contributed by:  
Micheal D. Munson  
Senior Vice President—Investments  
A.G. Edwards  
1501 N. University, Suite 100  
(501) 664-9135



**Y**ou've spent years growing your wealth and planning your estate, so it is just good sense to plan to protect your assets and pass them on to your beneficiaries according to your wishes. When you're ready to sit down with your financial professional and develop an estate plan, keep these tips in mind.

**Write a will.** If you do not have a will when you die, the law of your state may then determine what happens to your estate, your assets and any minor children. In addition, the state process, usually governed by probate court, is often slow, sometimes expensive and open to the public.

**Fund a living trust.** Follow through as you set up a living trust. Until you transfer ownership of property or assets to it, the trust is not worth any more to you or your beneficiaries than the paper its printed on. Unfortunately, many revocable living trusts are set up but remain unfunded.

**Re-Title 'JROWS' property.** Joint-Tenancy- With-Right of Survivorship titling of assets may result in estate planning headaches. Although probate is avoided at the first joint owner's death, it is not avoided at the death of the survivor, thus only delaying estate taxes. Re-titling assets to a credit

shelter trust can help avoid probate and provide estate taxes savings.

**Use both spouses' applicable exclusion amount.** Leaving all property and assets to a spouse may avoid estate taxes at the death of the first spouse, but this approach wastes the gift and estate tax credit of the "first-to-die." A credit shelter trust can maximize each spouse's credit, thus sheltering more assets from estate tax liabilities.

**Re-title ownership of life insurance policies.** Most life insurance policies are owned by the insured, causing the policy's face amount to be included in that person's estate at his or her death. Policy owners may consider giving policies directly to the beneficiary or transferring the policies to an irrevocable insurance trust. Either strategy could help reduce taxes.

**Choose an appropriate executor.** Naming an inexperienced family member as executor could complicate the demanding task of settling your estate. This is especially true at a difficult and emotional time following a death. Look into the benefits of naming a professional organization to follow through with the duties of an executor.

**Organize your paperwork and files.** If you do not provide your executors and beneficiaries with all the paperwork or files pertaining

to your property, assets and wishes, improper distribution and management of your estate may result.

**Update your estate plan.** Updating your estate plan from time to time is important so that it is implemented exactly according to your wishes. You will want to update your estate plan when there are changes in your family (births, marriage, divorces, deaths, etc.), or when the value of your estate significantly increases or decreases, when tax laws change, if you move to another state or if your business or career changes.

**When you are ready to begin** your estate planning strategies, talk to your financial advisor. Be sure to consult your tax and legal advisors as well before making any tax-related or legally related investment decisions.

If you would like to learn more, please write to us in care of Arkansas Business Publishing Group, 201 E. Markham St., PO Box 3686, Little Rock, AR 72203, to the attention of Stephanie Hopkins.

---

*This article does not constitute tax or legal advice. Consult your tax or legal advisors before making any tax-related or legally related investment decisions. This article is published for general informational purposes and is not an offer or solicitation to sell or buy any securities or commodities. Any particular investment should be analyzed before on its terms and risks as they relate to your circumstances and objectives.*

## COMMUNICATIONS COORDINATOR

Judy Hicks

## EXECUTIVE VICE PRESIDENT

Kenneth LaMastus, CAE

## ASSISTANT EXECUTIVE VICE PRESIDENT

David Wroten

## EDITORIAL BOARD

Sue Chambers, MD	Pediatrics
Joseph M. Beck, II, MD	Oncology
Lee Abel, MD	Internal Medicine
Samuel Landrum, MD	Surgery
Jerry Kendall, MD	Family Practice
William Ackerman, MD	Anesthesiology

## EDITOR EMERITUS

Alfred Kahn Jr., MD

## ARKANSAS MEDICAL SOCIETY 2000-2001 OFFICERS

Gerald A. Stolz, Jr., MD, Russellville  
*President*

Joe Stallings, MD, Jonesboro  
*President-elect*

Paul A. Wallick, MD, Monticello  
*Vice President*

Lloyd G. Langston, MD, Pine Bluff  
*Immediate Past President*

Carlton L. Chambers, III, MD, Harrison/Little Rock  
*Secretary*

Dwight M. Williams, MD, Paragould  
*Treasurer*

Anna Redman, MD, Pine Bluff  
*Speaker, House of Delegates*

Kevin Beavers, MD, Russellville  
*Vice Speaker, House of Delegates*

Joseph M. Beck, II, MD, Little Rock  
*Chairman of the Council*

Established 1890. Owned and edited by the Arkansas Medical Society and published under the direction of the Council.

**Advertising Information:** Contact Stephanie Hopkins, P.O. Box 3686, Little Rock, AR 72203; (501) 372-2816.

**Postmaster:** Send address changes to: *The Journal of the Arkansas Medical Society*, P. O. Box 55088, Little Rock, Arkansas 72215-5088.

**Subscription rate:** \$30.00 annually for domestic; \$40.00, foreign. Single issue \$3.00.

**The Journal of the Arkansas Medical Society** (ISSN 0004-1858) is published monthly by the Arkansas Medical Society, #10 Corporate Hill Drive, Suite 300, Little Rock, Arkansas 72205. Printed by The Ovid Bell Press, Inc., Fulton, Missouri 65251. Periodicals postage is paid at Little Rock, Arkansas, and at additional mailing offices.

**Articles and advertisements** published in *The Journal* are for the interest of its readers and do not represent the official position or endorsement of *The Journal* or the Arkansas Medical Society. *The Journal* reserves the right to make the final decision on all content and advertisements.

Copyright 2001 by the Arkansas Medical Society.

## COMMENTARY



# IS THAT SO?

SAMUEL E. LANDRUM, MD, FACS

So much of what we learned in early medical education 30 or 40 years ago has been shown either to be unnecessary or to be so opposite current practices that it is humbling.

One of the duties of the night resident was to insert Levin tubes early in the morning in all who were scheduled to have their gall bladder removed that day. Long intestinal tubes were passed per os prior to elective intestinal resection, and colon-resection patients were in the hospital for four days pre-op for a thorough prep.

Some of these practices were continued in the early years of my private practice because they had been stressed so much for patient safety. Fortunately, brave surgeons or patients defied the standard practice and led to the discovery that the tubes did not add to safer operations with fewer complications. Improvements in anesthetic techniques and agents have probably contributed in a major way to this change.

Reflection on those and other changes in medical dicta have made me wonder what is right and true. Dwelling on these reflections can be almost depressing.

Recently, two papers reporting experience with CT scans and ultrasonography in suspected cases of appendicitis were presented at a meeting of surgeons.

The first review of 776 cases seen at the University of California at Davis showed that the long-observed symptoms and signs of appendicitis were more predictive of the correct diagnosis and that CT and US should be used rarely and selectively. Obtaining these studies delayed getting to the correct diagnosis and operation.

The second study, reported from Scott and White Memorial Hospital in Texas, found that CT scans of the RLQ and pelvis substantially improved the accuracy of diagnosis, especially in females in their teens and early reproductive years.

These studies probably will be in the *Archives of Surgery* next spring if one is interested in the details of these reports. This is a current area of disagreement among various radiologists, surgeons, primary-care, and emergency physicians.

At the same meeting, there was a panel of four surgeons on groin hernia repairs, and there was considerable divergence of preferences for various techniques. Use of mesh, which approach, or whether laparoscopic exposure is good were not points of universal agreement.

These are simply two recent exposures dealing with common surgical procedures that I enjoyed. Yet when listening to the speakers with obvious, different convictions, I had to remember, "Is that so?" ■

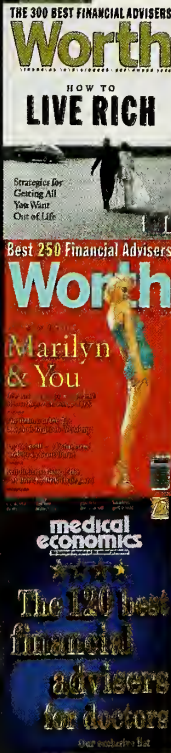
*Dr. Samuel E. Landrum is a retired general surgeon from Fort Smith. Dr. Landrum is a member of the editorial board for The Journal of the Arkansas Medical Society.*



Two of the best financial planners in the nation are in Arkansas.

**CINDY CONGER**  
MBA, CPA/PFS, CFP

**RICK ADKINS**  
MBA, CFP, ChFC



They can be found at The Arkansas Financial Group.

Since 1985, we've been helping busy people make smart financial decisions. So next time you're looking for objective answers to life's crucial financial decisions, call The Arkansas Financial Group. You'll be in great company.

Here's what the editors of *Worth* and *Medical Economics* had to say:

*"The Best 150 Financial Advisers for Doctors, 8/00"*

*"The Best 250 Financial Advisers, 9/99"*

*"The Best 300 Financial Advisers, 9/98"*

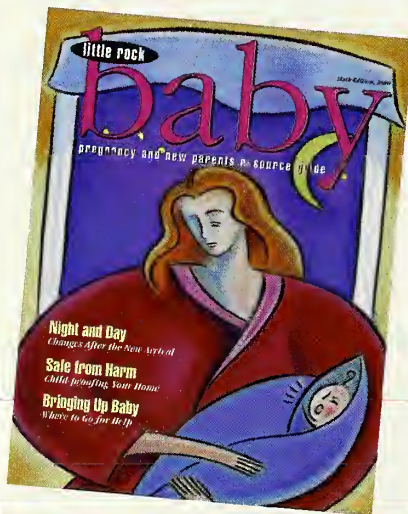
*"The Best 250 Financial Advisers, 10/97"*

*"The 120 Best Financial Advisers for Doctors, 7/27/98"*

*"Fee-only, objective, customized, comprehensive, affordable advice"*

**The Arkansas  
Financial Group, Inc.**  
**376-9051**

PHOTO: KELLY QUINN/TERRITORIAL RESTORATION



What Every Parent Needs  
For Their Experience  
Of A Lifetime...

(Even if it's the second or third experience)

For advertising information  
call Stephanie Hopkins  
(501) 372-1443. Ext. 293

ARKANSAS BUSINESS PUBLISHING GROUP

## Davis Properties



**Clinic space for lease in the  
heart of West Little Rock  
13100 Chenal Parkway**

Contact Max or Greg Davis  
at 501-225-1000 for more information



Original manuscripts are accepted for consideration on the condition that they are contributed solely to this journal. Material appearing in *The Journal of the Arkansas Medical Society* is protected by copyright. Manuscripts may not be reproduced without the written permission of both author and *The Journal of the Arkansas Medical Society*.

*The Journal of the Arkansas Medical Society* reserves the right to edit any material submitted. The publishers accept no responsibility for opinions expressed by the contributors.

All manuscripts should be submitted to Judy Hicks, Arkansas Medical Society, P.O. Box 55088, Little Rock, Arkansas 72215-5088. A transmittal letter should accompany the article and should identify one author as the correspondent and include his/her address and telephone number.

#### MANUSCRIPT STYLE

Author information should include titles, degrees, and any hospital or university appointments of the author(s). All scientific manuscripts must include an abstract of not more than 100 words. The abstract is a factual summary of the work and precedes the article. Manuscripts should be typewritten, double-spaced, and have generous margins. Subheads are strongly encouraged. The original, one copy and the manuscript on a 3-1/4" diskette should be submitted. Pages should be numbered. Manuscripts and diskettes are not returned; however, original photographs or drawings will be returned upon request after publication. Manuscripts should be no longer than eight typewritten pages. Word count should not exceed 1,700. Exceptions will be made only under most unusual circumstances.

#### REFERENCES

References should be limited to ten; if more than ten are listed, the author(s) may designate the ten most significant to be printed and readers will be referred to the author(s) for the complete list. References must contain, in the order given: name of author(s), title of article, name of periodicals with volume, page, month and year. References should be numbered consecutively in the order in which they appear in the text. Authors are responsible for reference accuracy.

#### ILLUSTRATIONS

Illustrations should be professionally drawn and/or photographed. Glossy black and white photos are preferred. They should not be mounted and should have the name of the author(s) and figure number penciled lightly on the back. An arrow should indicate the top of the illustration. In photographs in which there is any possibility of personal identification, an acceptable legal release must accompany the material. Up to four illustrations will be accepted at no charge to the author(s). If more than four are necessary, it is understood that the author(s) will be responsible for the reproduction costs.

#### REPRINTS

Reprints may be obtained from *The Journal* office and should be ordered prior to publication. Reprints will be mailed approximately three weeks from publication date. For a reprint price list, contact Judy Hicks at *The Journal* office. Orders cannot be accepted for less than 100 copies.



## Prompt-Payment Rule Moves Forward

By DAVID WROTEN

**T**here is no question that one of the most important issues for Arkansas physicians has been prompt payment of insurance claims. For nearly two years, the leadership and staff of the Arkansas Medical Society have placed this issue at the top of their agenda. The hard work may finally be ready to pay off.

Jan. 1, 2001, was the implementation date of the Arkansas Insurance Department's new prompt-payment rule, known as Rule 43. The Arkansas Medical Society and the Arkansas Hospital Association negotiated with the insurance industry for the better part of last year to craft a regulation that is, it is hoped, fair and enforceable. The Insurance Department adopted the proposal with only minor modifications.

A big victory for physicians and other health care providers is a new requirement that the department investigate complaints filed by providers. Previously, the department only recognized complaints filed by patients. The new provision allows providers to file consumer complaints *where there is a reasonable basis to believe that the health carrier has exhibited a practice of not paying that providers' claims according to the rule.*

In other words, a physician's office cannot file a complaint over just one claim. The bottom line is that if a physician is having claim problems with a specific carrier, the Insurance Department will, for the first time, investigate the complaint. This is a major step forward.

Other key provisions of the rule:

- Clean claims must be paid or denied in 30 days if submitted electronically, or in 45 days if submitted by other means.
- For claims that require additional information, the carrier has 30 days from receipt of the claims to request the information. After receipt of the information, the claims must be paid or denied within 30 days.
- Carriers that fail to process clean claims within 60 days must pay the provider a penalty of 12% per annum. The same penalty applies to other claims not processed within 45 days of receipt of the additional information. The penalty must be paid automatically and without any action by the provider.

The rule establishes a standard for timeliness, requiring 85% of all claims to be processed within 30 days and 98% within 45 days. If the carriers' claim-filing practices fall below a certain minimum standard, regulatory intervention is triggered. The minimum standard is 60% of claims processed within 30 days and 85% processed within 45 days.

So what is a *clean claim*? The AMS reviewed clean claim definitions from across the country without finding a single, clear, unambiguous definition. The language that was finally agreed to provides that a clean claim is one submitted on an HCFA 1500 or other standard form with all required fields completed *in accordance with the health carriers' published claim-filing requirements.*

There are the usual provisions stating what is not a clean claim, such as a claim that requires additional information. However, another important provision requires the carrier to provide you with a copy of its claim-filing requirements upon request. These must be published, and complaints can be filed with the Insurance Department if they are unreasonable. The commissioner can order the carrier to alter or discontinue requirements that are unreasonable or unduly burdensome.

This new regulation is not a silver bullet and will not stop some carriers from bending or trying to break the rules. However, for the first time, there is a regulatory arena that physicians can turn to for settling these disputes.

This has been another example of your AMS at work for you. ■





*The Young brothers celebrate at Dr. David Young's wedding. From left to right, Matthew, Chris, John, Holly, David, Patrick, Tom, Mark and Michael.*

# Family Ties

## *Medicine Runs Deep in Some Arkansas Families*

BY NATALIE GARDNER AND MARK FRIEDMAN

*Editor's Note: Medicine is often a family affair. Those who practice it for 30 or 40 years tend to pass the tradition on to bright sons and daughters or nieces and nephews. Children see how their elders helped others, and many are ready to do the same once they are grown. My dad followed in his uncles' footsteps and became an ophthalmologist. He looked up to those men and knew that if they found the field fulfilling, he would, too. He learned from them that medicine is a good way to help others while making a good living for him and his family.*

*That's exactly what the eight sons of Dr. Mitchell Young of Texarkana discovered. They admired their dad in his career and were eager to carry on the family tradition. And once the first few sons made the leap, it wasn't hard for the others to follow.*

*The same goes for Drs. Dennis and David Jacks of Pine Bluff. Although their father wasn't a physician, the entire family was active in the community. Medicine was a natural step for all these brothers — their way of giving back to society.*

Dr. Mitchell Young's oldest son announced he wanted to follow in his dad's footsteps and become a doctor.

Then his brothers jumped on the bandwagon.

In the end, all eight of Young's sons became doctors. Five are orthopedic surgeons, two are emergency-medicine doctors, and the youngest son is a veterinarian. One of Dr. Young's two daughters went into the health profession, becoming a registered nurse. The other daughter is a teacher for the U.S. Department of Defense in Stuttgart, Germany.

Of course, the Young brothers are used to the typical questions: Was your dad the inspiration for you all? Do you guys talk about medicine when you get together?

But to families like the Youngs, medicine is "in the genes."

Dr. Young, 72, knew he wanted to go into medicine when he was 6, after being hit by a car, suffering a broken leg, in his hometown of Texarkana, Texas, where he lives now.

"I just thought it was a way to help people," he said. "I thought it was what I should do."

Even Dr. Young's wife has the medical drive. She was a nurse before having 10 children in 14 years.

Dr. Young's parents, both accountants, taught him the value of hard work. While in school, Dr. Young peddled papers and worked at a Boy Scout camp while keeping an eye on becoming a doctor.

After graduating from the University of Arkansas, he went to the University of Arkansas Medical School in Little Rock, graduating in 1953.

While he was doing his residency at St. Louis City Hospital, he met his future wife, Donna, and fell in love. They were married in 1955. After three additional years of training at Southwestern Medical Center/Parkland Hospital in Dallas, Dr. Young opened his general surgery practice in his hometown, where he practiced for 41 years until his recent retirement.

### **The Value of Hard Work**

Sitting at his dining room table in his two-story white brick house, Dr. Young said he and his wife instilled a good work ethic, discipline and faith in all of their children.

Watching the children grow up, Dr. Young noticed that they were determined and worked hard at what they did. They also excelled at sports and had good hand-eye coordination, a plus in the operating room.

"I hoped they would go into medicine, but I never pushed medicine on them," he said. He just wanted them to be happy in the profession they chose.

Dr. Young and his wife gave their children chores to do around the house and on their 70-acre farm.

One summer, the boys spent a week building a barbed-wire fence around the ranch.

"It taught them hard work and responsibilities and working together," Dr. Young said. "It [also] taught them perseverance."

Another valuable life lesson for Dr. Young and his children came from the Boy Scouts of America.

"I started out in Boy Scouts when I was 12, and it has meant so much in my life," Dr. Young said. "I think all young men should be members of Boy Scouts, and girls should be members of Girl Scouts. I really feel strongly about that."

Scouting teaches youngsters to depend on themselves, to survive in the outdoors and to become community leaders, Dr. Young said.

"But mostly you learn to be a citizen of this country and do the best at whatever you do," he said.

In the Young household, before

the teen-agers were allowed to drive, they had to earn their Eagle Scout award.

All the sons accomplished that goal, giving the family the honor, for a time at least, of having the most Eagle Scouts. The girls also had to earn the Girl Scouts' equivalent of the Eagle Scout award before they could drive.

"I think scouting and strong religious life ... were the keys [to the children's success]," Dr. Young said.

Dr. John Young, 34, an orthopedics and sports medicine specialist in Shreveport, La., said scouting was a major force in his life and one of the reasons he decided to go into medicine.

"Medicine seemed like a natural step after Boy Scouts," he said. "Many of the things we learned in Boy Scouts apply to medicine, such as taking care of people."

Outside of scouting, the Young family spent a lot of time together at the children's various sporting events, namely football and tennis.

Dr. Mitchell Young, a former Razorback football player, also instilled his love of sports in his sons.

"You have to learn to be tough, and you learn that in athletics," he said.

Dr. Chris Young, 35, an orthopedic surgeon in Hot Springs, said the brothers' involvement in sports was one of the main reasons five of them chose orthopedics as their specialty.

"I had both my shoulders operated on during high school because of football," he said. "Orthopedics tends to be full of the good old boys and jocks. It was really competitive, and you had to be at the top of your class to get into orthopedics. For me, it was something to shoot for."

### **Becoming Doctors**

The oldest sibling, Dr. Michael Young, 44, a partner with Chris in Hot Springs, was the first to choose medicine as a career and orthopedics as a specialty.

The second oldest son, Mark, 43, an orthopedics specialist in Mount Pleasant, Texas, and third-oldest son, Dr. Tom Young, an orthopedics specialist in Texarkana, soon decided to head to medical school, too. Pretty soon, all the boys were in medical school.

At one time, four — John, Chris, David and Matthew — were studying at the University of Arkansas for Medical Sciences.

## ***A Guide to the Young Family***

**With so many successful children, it's hard to keep up with the Young family, but here's a look at Dr. Mitchell and Donna Young's children and where they are.**

**Dr. Michael Young, 44, of Hot Springs, orthopedics**

**Dr. Mark Young, 43, Mount Pleasant, Texas, orthopedics**

**Lesa Young, 42, Benton, registered nurse**

**Dr. Thomas Young, 41, Texarkana, Texas, orthopedics**

**Mary Young, 39, Stuttgart, Germany, teacher**

**Dr. David Young, 37, Searcy, emergency medicine**

**Dr. Chris Young, 35, Hot Springs, orthopedics**

**Dr. John Young, 34, Shreveport, La., orthopedics**

**Dr. Matthew Young, 32, Texarkana, Texas, emergency medicine**

**Dr. Patrick Young, 31, Washington, Okla., veterinary medicine**



John and Chris were in the same medical school class, while older brother David was just a year ahead of them. Younger brother Matthew was two years behind them.

"Chris and I helped each other through medical school, which was a big help," Dr. John Young said.

Going into orthopedics wasn't a hard decision for John, who was eager to follow in his dad's and older brothers' footsteps. "I've always looked up to my older brothers."

David, 37, a physician in Searcy, and Matthew, 32, a physician in Texarkana, are the two brothers who went the route of emergency medicine. The youngest sibling, Dr. Patrick Young, 31, is a veterinarian in Washington, Okla., working exclusively on horses.

"I wanted to be a cowboy and a doctor, so this was a good choice for me," Dr. Patrick Young said.

Patrick performs surgeries and rehabilitation on race and show horses. His daily routine is not far off from his brothers' in orthopedics.

"Horses are athletes," he said. "What I do is a lot like doing human orthopedics. We can do a lot for these horses to improve their performance."

### Following in Dad's Footsteps

Dr. Mark Young said he thinks so many of his siblings went into medicine because his dad set a good example. Dr. Mitchell Young would tell his children that they were blessed to live in the United States, where they could get an education, and that they owed it to society to give something back, Mark said.

Mark remembers seeing people come to his house for medical help. People would also go up to his dad and tell him he saved their lives. He also remembers seeing his father cry after losing patients.

Matthew, the second youngest sibling, said he couldn't put his finger on why his family had the medicine bug. But he said the help-others attitude of his parents played a big role.

"It's a profession where you can help your fellow man and feel like you accomplished something at the end of the day," Matthew said.

Another reason the brothers chose medicine is that the family is so close.

The brothers refer to one another as best friends and look forward to getting together at the family's cabin outside Hot Springs.

"Holidays are a big time for our family," Dr. John Young said. "And Razorback games are, too. We all end up at the cabin, put the Razorbacks on the radio, barbecue and just have a great time. We're all avid outdoors people, so we go to the cabin and mountain-bike, canoe and hike."

But the family passion is duck hunting. Chris said duck hunting was one reason he and John stayed at home and went to a junior college for two years before heading to the University of Arkansas at Fayetteville.

"We'll all get together to go duck hunting and spend the night in one of those huge outfitter's tents with a stove in it," Chris said. "Mark will cook his famous cobbler, and we'll make a huge breakfast the next morning."

When they get together, medicine doesn't always rule the conversation, Chris said.

"We talk about medicine some, about interesting things that we've seen," Chris said. "But we're really down-to-earth, regular guys. We talk about other things, like everyone's family or who we've seen lately."

One thing all the brothers agree on is the kudos their parents should get for raising 10 successful children who are all giving back to society.

"Dad set such a wonderful example for us," John said. "He was happy, and we could tell. All the credit goes to our mom and dad."

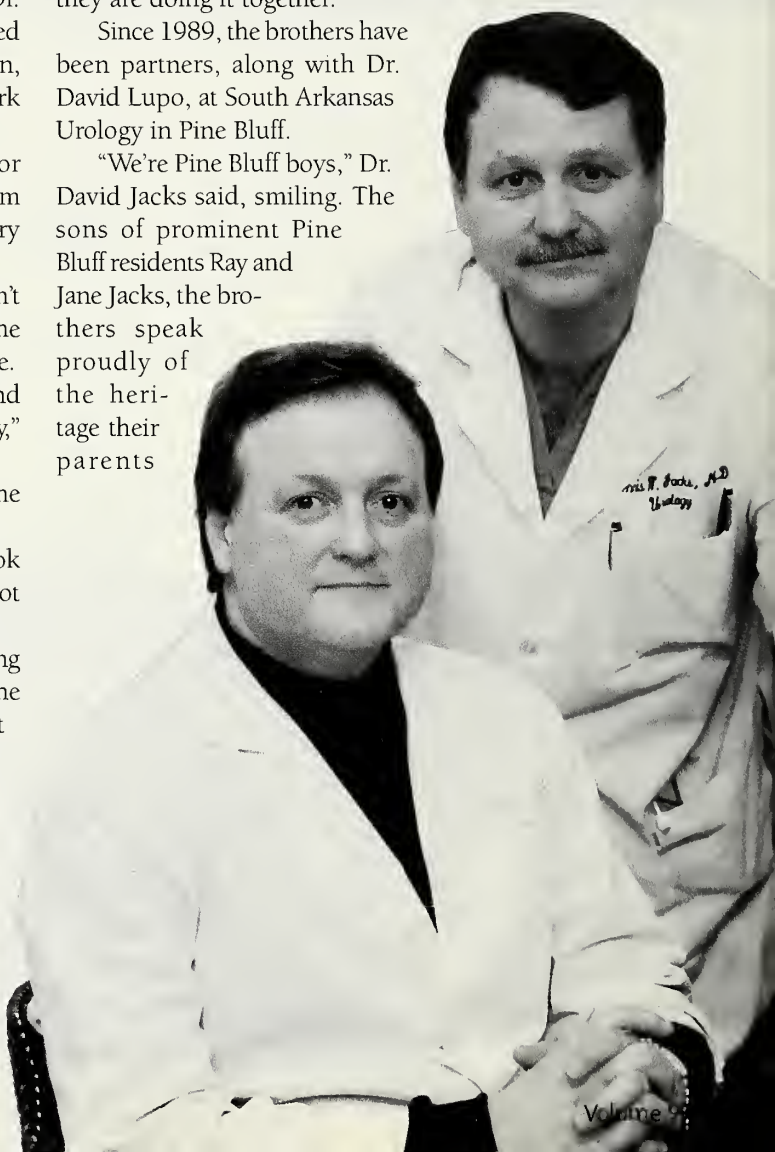
"Dad was the best example I could have had," Chris said. "I learned that I could help people and make a good living at it, too. I really am extremely happy being a physician. Being a servant is a wonderful way to make a living."

### The Jacks Brothers

Drs. David and Dennis Jacks have a commitment to improving the health of their hometown residents — and they are doing it together.

Since 1989, the brothers have been partners, along with Dr. David Lupo, at South Arkansas Urology in Pine Bluff.

"We're Pine Bluff boys," Dr. David Jacks said, smiling. The sons of prominent Pine Bluff residents Ray and Jane Jacks, the brothers speak proudly of the heritage their parents



*Brothers David and Dennis Jacks of Pine Bluff enjoy their working partnership.*

Photo: Kirk Jordan

gave them. Jane Jacks worked for years in Pine Bluff's paper production industry, while Ray Jacks spent 50 years with the Pine Bluff Fire Department, 27 as fire chief. Ray Jacks also worked on his off days at Western Union and was active in the Democratic Party.

"People tried to get him to run for mayor," Dr. David Jacks said, but he was not interested in professional politics.

The brothers agreed that their mother's strong work ethic and their father's emphasis on education put them on the path toward medicine. And serving as teen-age orderlies at Jefferson Regional Medical Center sent them further on their way.

Dr. David Jacks, 50, returned to Pine Bluff in 1981 immediately following medical school and his residency. In 1986, he recruited Dr. David Lupo as a partner. Three years later, his brother left the military to join them.

One of the biggest challenges the brothers face in their practice is that they have the same last name. Patients and insurance representatives often get confused.

"I'm trying to get him to change his name," Dr. Dennis Jacks, 48, said, joking.

*One of the biggest challenges the brothers face in their practice is that they have the same last name.*

*Patients and insurance representatives often get confused.*

But the brothers seem to enjoy their partnership. Because of their two-year age difference, Dr. Dennis Jacks never really felt much sibling competition. "We didn't really run around together. David had older friends and I had younger friends," he said.

Their lives have had strong parallels, though. In addition to attending the same medical school, both are divorced fathers

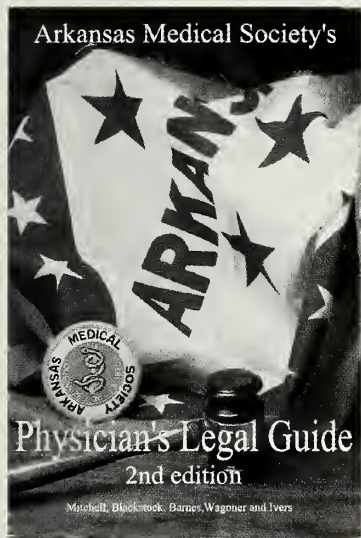
who enjoy hunting and the outdoors. Both of their sons also followed in their fathers' footsteps by becoming orderlies at Jefferson Regional Medical Center. David has two sons, Bradley, 17, and Blake, 13, while Dennis has three children, William, 21, Ashley, 19, and Megan, 15.

When asked if any of their children were headed to medical school, both men were hopeful.

"My 13-year-old wants his name out here in front of this building. He wants to, not because I want him to. He's going to make it on his own. My older son, Bradley, wants to be a neurosurgeon one day, an oral surgeon the next day and nothing the next day," David said, laughing.

Only time will tell if the tradition will continue. ■

*Susan Van Dusen contributed to this story.*



## 2nd edition Arkansas Medical Society's Physician's Legal Guide

Be one of the first to obtain this guide which contains a multitude of state and federal laws affecting the practice of medicine. This guide is a valuable resource for physicians, clinic and hospital administrators, office staff, attorneys, regulators and many others.

Call the AMS office at 501-224-8967 or 800-542-1058 for volume discount pricing.

**\$87<sup>00</sup>**  
List Price

**\$65<sup>00</sup>**  
for AMS  
members

**A 25%  
Discount!**

(Prices include shipping and handling.)

Check enclosed in the amount of: \$ \_\_\_\_\_

Please charge my Visa or Mastercard:

Cardholder's name: \_\_\_\_\_

Credit card No.: \_\_\_\_\_ Exp. date: \_\_\_\_\_

Cardholder's Signature: \_\_\_\_\_

☐ Please check if you are  
an AMS member.

Name: \_\_\_\_\_

Clinic: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_ Fax No.: ( ) \_\_\_\_\_

**CREDIT CARD ORDERS  
CAN BE FAXED TO:  
(501) 224-6489**



# Meet Our Members

## Dwight M. Williams, MD

By CHRISTY L. SMITH

Dr. Dwight M. Williams believes in a strong family unit. A childhood accident involving his brother and the death of his oldest daughter eight years ago reinforced that idea, he said.

"I can't think of anything good about the deterioration of the family structure," he said. "I believe that if you don't have a strong family unit, you will not succeed."

The 49-year-old family practice physician at Paragould Doctors' Clinic was one of six children born to blue-collar parents. A childhood accident in which his younger brother, Wallace, lost two fingers piqued Dr. Williams' interest in medicine, he said.

"I was 8, and he was 5. We were playing with an old lawn mower, and I ended up amputating a couple of his fingers," Dr. Williams said.

The family's physician, Dr. Jacob Williams (no relation) of Paragould, was able to reattach one of the fingers. The family practice physician's ability to handle such an injury inspired Dr. Williams, he said.

Dr. Williams, a native of Paragould, graduated with a degree in zoology from Arkansas State University in Jonesboro in 1975. He enrolled at the University of Arkansas for Medical Sciences in Little Rock in 1976. After graduation, Dr. Williams completed a family practice residency and internship at the Arkansas Area Health Education Center in Jonesboro. He has been in

private practice since 1983. He has been one of four partners at Paragould Doctors' Clinic since 1986.

Dr. Williams said it was always his intent to go back to Paragould to practice even though he had heard that small-town physicians were often "inundated by requests from family and friends" to treat their ailments. But Dr. Williams hasn't had to grapple with that problem because he adheres to a personal rule against treating close relatives, he said.

"I treat some, but not close, relatives. It would be hard to make life and death decisions for my wife and children," Dr. Williams said.

Dr. Williams met his wife, Judy, a former registered nurse, while the two were attending ASU. By working at Doctors' Hospital in Little Rock, Judy Williams helped put her husband through medical school. She left nursing about 20 years ago to raise the couple's three children.

The Williamses' oldest daughter was killed eight years ago in an automobile accident. Dr. Williams' mother-in-law was driving the car, which hydroplaned during a thunderstorm, he said. The accident had a lasting effect on the Williams family.

"It was a profound experience, losing a daughter. It was a stress on the family, but it was something we were stronger for afterward," he said.

Family closeness helped the Williamses through that difficult period, he said.

"My wife was very supportive, even though she had to be hurting. And having two other children gave us the will to get through it. I can't imagine losing an only child and not having the family support to fall back on," he said.

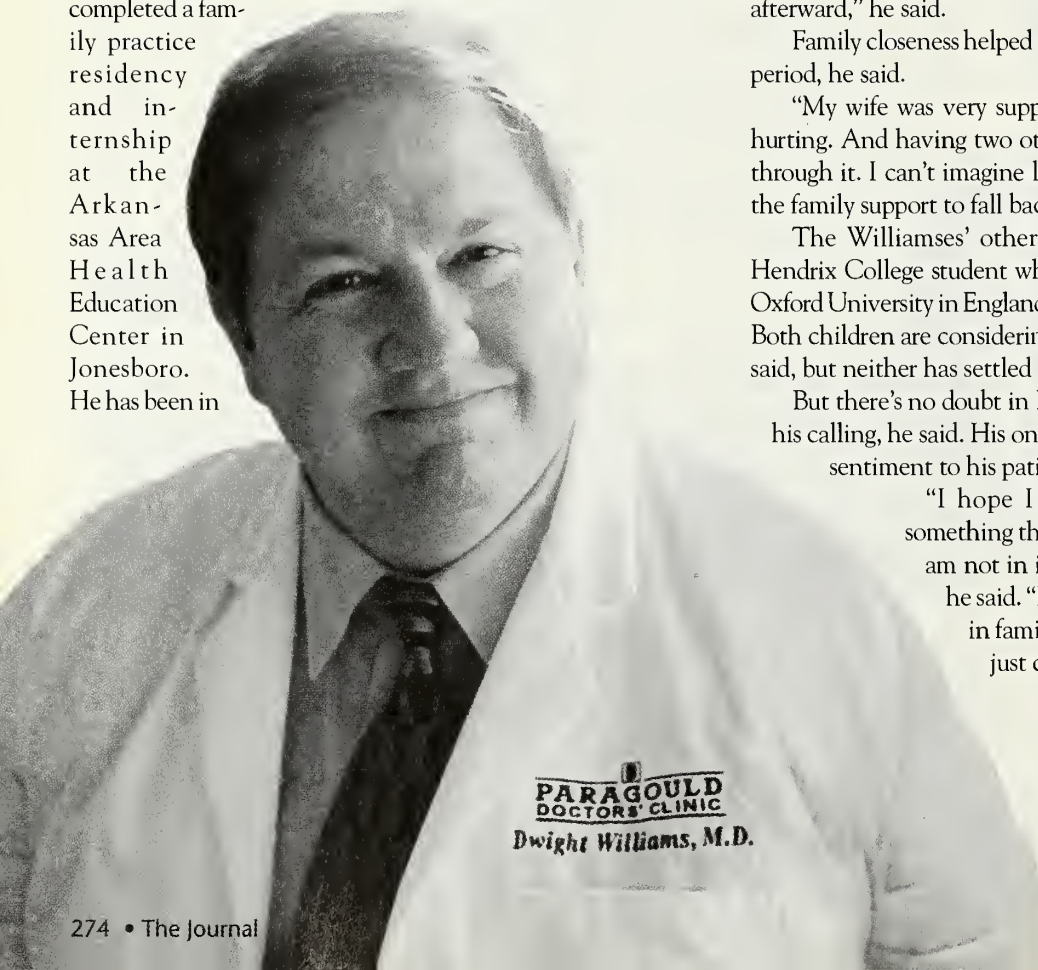
The Williamses' other children are Traci, a 20-year-old Hendrix College student who recently completed a semester at Oxford University in England, and Jarrod, 18, a high school senior. Both children are considering careers in medicine, Dr. Williams said, but neither has settled on a distinct course yet.

But there's no doubt in Dr. Williams' mind that medicine is his calling, he said. His only hope is that he has conveyed that sentiment to his patients.

"I hope I have always given my patients something they could rely on [and the idea that] I am not in it for just the business of medicine," he said. "I have certainly gained a lot by being in family medicine. I learn every day, and I just can't imagine doing anything else."

*Dr. Dwight Williams, AMS treasurer, says his family has learned a lot from the death of his oldest daughter.*

Photo: Kirk Jordan



Dr. Williams said that 40% of his patients are elderly but that he particularly enjoys the pediatric aspect of the profession.

When he was in medical school, he said, "I was within a day of going to a pediatric residency but changed my mind. I lost a real close patient in pediatrics and wasn't sure at the time that I could handle that. I thought I would be better suited doing family practice."

Dr. Williams' day begins at 7 a.m. with rounds at Arkansas Methodist Hospital in Paragould. He usually sees four to eight patients there and then starts work at the clinic at 9 a.m., attending to the "typical family medicine" problems of about 50 patients by the end of the day, he said.

Although he maintains a busy schedule, Dr. Williams tries to spend his one-hour lunch break every day with his wife because "that's the one meal we can almost guarantee ourselves together," he said.

Dr. Williams' day usually ends at 6 p.m., although he shares call duties with seven other doctors.

"I don't know how people did it 20 years ago, taking their own call 24/7," he said, adding that in the old days he probably would have chosen a different specialty to escape the demands on his time.

Dr. Williams said he had seen many changes in the practice of medicine during the past 17 years, including managed care and patient tolerance.

With so many changes, Dr. Williams said he has relied heavily on the Arkansas Medical Society.

"Most doctors aren't aware of all the ins and outs of how medicine interacts with other entities, such as insurance companies and legislators," he said. "It takes several years to learn how all that works, but the Society helps its members keep tabs on it all."

When he began practicing in 1983, managed care "was not an issue. Doctors would see anybody who walked in," he said. But managed care arose in Paragould in the late 1980s "when some of the private industries developed a primary-care network," he said.

As a result, it is now harder for a physician to go into solo practice in Paragould, Dr. Williams said.

"He can get in [the network], but it may take 12 months to get through all

the paperwork and jump through all the hoops," he said. Most area doctors enter solo practice "after they've been established for a while."

"The Society has been there looking out for our interests when managed care looks at cutting costs," he said. "When they start to cut, they first look at hospital and doctor budgets. I understand their problem, but they are looking for a quick fix, and cutting doctors' fees hurts everybody, especially the patients. The Society is a huge advocate for patients."

Another change is that patients and "everyone associated with medical care" want answers to health problems within hours, Dr. Williams said. "People aren't as patient, and that puts us all in a hurried pace."

One thing Dr. Williams is not in a hurry to do is retire. He said he would practice full time for another decade and then scale back his practice, possibly embarking on overseas mission trips and serving locum tenens, or as a fill-in physician for those who need to take time off.

"I don't think I would be happy not working," he said.

Dr. Williams has already embarked on one mission trip. For seven days in December, he helped run a clinic in an underserved area of Romania.

"My partner had been on a couple of mission trips before, and he said they needed to sign up another doctor," he said. "They wanted a doctor, a plumber and a preacher, and I knew I could handle at least one of those."

Dr. Williams has been a member of the Arkansas Medical Society since 1983. He served as first district councilor from 1990-98 and has completed two years as the society's treasurer.

Dr. Williams was appointed to the Arkansas State Board of Health by Gov. Jim Guy Tucker in 1993 and was reappointed by Gov. Mike Huckabee in 1998.

In his free time, Dr. Williams enjoys gardening and is a licensed pilot. But his favorite pastime is scuba diving in the Caribbean with his children. "That was an interest they had, and, at 12 or 13 years old, they needed somebody to be their buddy. It's a good family thing to do together," he said. ■

## ARCHITECTURE

FOR YOUR MEDICAL NEEDS

1 800 764 ASTI



William Henry Asti, AIA  
architects, economists, development consultants

## ST. VINCENT HEALTH SYSTEM

- OB/GYN
- CARDIOLOGY
- HOSPITALIST

Actively searching for physicians to practice in Little Rock. If you have an interest or know someone interested in an opportunity, please contact Faye G. Stewart at St. Vincent Health System. (501) 660-3245 or 1-800-482-1288 ext. 3245

+ CATHOLIC HEALTH INITIATIVES

### St. Vincent Health System

INTENSIVE CARING.

[www.stvincenthealth.com](http://www.stvincenthealth.com)



# Collect Bad Debt

- Cheaper
- Faster
- In compliance with the Law



If you've always used a collection agency. . . WHY?

Cut out the collection agency by retaining the Maggio Law Firm.

Save time. Save money.  
Be in compliance with the law.

Have you always used a collection agency because "that's the way you've always done it?"

*Try a new way. . . tip the scales in your favor, call today.*

## MAGGIO LAW FIRM

*your collection law firm*

Offices in Conway and Searcy • 1-800-600-3201  
[www.ebaddebt.com](http://www.ebaddebt.com)



## We Focus On Heart Month 365 Days A Year.

February is Heart Month. A time when the world of medicine focuses on the importance of keeping the heart healthy and treating it when it's not. At Arkansas Heart Hospital, we focus on the heart year round, because your heart works 24 hours a day, every day of the month, every month of the year. We just thought you should know. **IN THE EVENT YOU NEED HEART CARE. AND IT'S NOT FEBRUARY.**

### ARKANSAS HEART HOSPITAL

*An entire hospital fighting heart disease. All year long.*

1701 S. Shackleford Road • Little Rock, AR 72211 • (501) 219-7000 • [www.arheart.com](http://www.arheart.com)



# A Horrible System for Everybody

J. KELLEY AVERY, MD

About one year after the surgery, a chest X-ray showed lesions in both the right upper and the left lower lobes of the lungs. These lesions progressed in size and the patient was advised that he was incurably ill.

## Case Report

The family physician had been this patient's doctor for about 10 years, during which time he had been treated for a few minor illnesses and injuries. This present episode of care began with the patient complaining of low back pain, to which he added, somewhat as an afterthought, that he was having some bright bleeding when he had a bowel movement.

He first noticed the blood in the commode mixed with the stool, but not on the toilet paper. The physician did a brief examination focused on the chief complaint of backache and rectal bleeding.

On rectal examination, the stool on the examining glove was negative for blood by guaiac test.

The patient was reassured and given some instructions relative to his low back pain, and he was told to conduct three consecutive examinations of the stool at home using the Hemoccult technique. The record does not indicate whether or not he complied with those instructions.

Within the month, the patient reported that he was still having some rectal bleeding, but there was no documented examination, and, from the record, the presumption was that he was advised by office staff to make an appointment and return about a week later.

On this return visit, the history was that the patient was having some bright bleeding with each stool but that he had not noted any tarry stools. This bleeding had been noticed more often during the last two weeks. There was no family history of colon cancer.

The examination revealed some comedones around the anal opening. At the five o'clock position on the anus, the physician noted a small fissure from which he believed the blood had come, though he found no blood on anoscopic examination.

The prostate was said to be enlarged, boggy, and slightly tender. The patient was given prescriptions for a sulfa derivative for his prostatitis, anal suppositories, and a bulk laxative. Warm soaks were advised as well.

Two weeks later, the patient's wife called to report that her husband was still having rectal

bleeding but that if asked, he would deny it. Indeed, when asked by an associate of the family physician's, the patient did deny the bleeding.

The wife again called and requested that her husband's doctor inquire about the bleeding. The patient was seen a few days later for an upper respiratory infection, and, at that visit, the physician recommended complete studies including sigmoidoscopic examination. The patient refused the referral.

Ten months after the initial complaint of rectal bleeding, the patient was seen by his doctor for complaints of abdominal cramping, some low back pain, and continued rectal bleeding.


The examination of the abdomen was negative for tenderness or masses, and bowel sounds were normal. The patient denied having constipation.

Anoscopic examination was repeated, with the same finding of a shallow fissure. Again a rectal examination was done, and this time the material on the examining glove was positive for blood. Both doctor and patient were increasingly concerned about the possibility of disease higher up in the bowel. A barium enema and a sigmoidoscopic examination were scheduled.

Examination revealed a flat lesion, vascular in appearance, which on biopsy was found to be a moderately well-differentiated adenocarcinoma of the rectum. The patient was referred to a colorectal surgeon who scheduled surgery, hoping to perform a primary anastomosis, but this proved to be impossible, making an abdomino-perineal resection with permanent colostomy the procedure of choice. The tissue specimen was examined in its entirety, and five lymph nodes were found to be positive for the cancer.

About one year after the surgery, a chest X-ray showed lesions in both the right upper and the left lower lobes of the lungs. These lesions progressed in size and the patient was advised that he was incurably ill. He was told that further treatment would prolong his life but that it would adversely affect the quality of his remaining months. He subsequently developed some mental changes, stumbling about and showing disorientation, which proved to be caused by brain metastases.





*Introducing the*

**DIAMOND STAR**

**Fast: 147 Knots / 169 MPH**

**Affordable: Ownership from 25% to 100%**

**And Fun!!!**

**CENTRAL FLYING SERVICE**

Call Cheri McKelvey  
501-975-9321

**SKYSHARE™**

A lawsuit was filed, charging the family physician with failure to diagnose and treat colon cancer in a timely manner. The case was tried, initially resulting in a jury verdict in favor of the physician. However, on appeal, the case was remanded to the trial court.

The trial had been a severe emotional strain on the family of the plaintiff and on the physician. Nobody wanted to repeat that experience. A settlement was reached for a relatively small amount.

### Loss Prevention Comments

Early in the course of the investigation of this lawsuit, a dispute developed between the patient and the physician as to whether the Hemoccult tests on the stool done early in the course of the patient's disease were reported to the physician.

The wife, the patient being disoriented and mentally incompetent at the time, insisted that they had informed the physician's office that the tests had all been positive. The physician insisted that the tests had not been reported and that consequently, he assumed the tests had been negative. There was no documentation either way.

It has to be pointed out that during the trial, the patient presented a pitiable picture, with his difficulty walking and his obvious mental and emotional deterioration. The trial was devastating for all concerned. On appeal, nobody wanted to repeat the experience, but a retrial was scheduled.

The plaintiffs' experts insisted that the delay of a year in conducting the definitive tests determined the bad result. The defense experts contended that no one could tell the time of onset of the cancer and that no one could tell whether the delay had anything to do with the outcome. However, with some testimony taking the physician out of an acceptable standard of care, and with the sympathetic picture of the plaintiff and his family, the settlement was accepted.

How should this family physician have conducted his care of this patient? On the first encounter with the complaint of rectal bleeding, the physician documented that he ordered three consecutive stool examinations, to be carried out by the patient himself. There was no documented report on these tests, though the plaintiffs contended that the



Healthcare Professional Liability  
Business/Workers' Compensation/Life & Retirement  
Planning

Managing the business side of healthcare is time consuming, but FARMERS helps get you back where you belong—delivering quality medical care.

For almost 50 years, Farmers Professional Liability has specialized in providing coverage and risk management solutions to the changing liability risks associated with the delivery of healthcare.

Our Physician Program offers solutions to, and exacting coverage for, today's broad spectrum risk exposures.

We make it simple—with one call we can handle all your insurance needs!



Mark Perry  
112 Municipal Drive  
Jacksonville, AR  
72076  
(501)982-4561  
1-800-467-2436  
mperry@alltel.net

Joanna Owens  
712 A Bradley Dr  
Mtn. Home, AR 72653  
(870) 424-2120  
1-888-424-2120  
baxterinsurance@yahoo.com





physician's office had been called and informed that the tests had been positive.

In the absence of a report on these tests, the physician assumed that the tests had been negative or that the patient had not done the tests as prescribed. On the next encounter, the patient again complained of rectal bleeding, and, thinking that the Hemocult tests had been negative, one physician did an anoscopic examination, found the anal fissure, and assumed it was the site of the bleeding.

It was treated, and it was eight months before the complaint was brought to the doctor's attention again. At this time, the attending physician advised the complete study, but it was refused by the patient. It was only after two months that the patient finally cooperated with the recommendation, the diagnosis was made, and definitive surgery was done.

The question remains whether or not the physician made logical clinical decisions on the basis of the information he had. The ending of the first trial in a defendant's verdict indicated that the jury believed that the attending physician had made clinical decisions within an acceptable standard of care.

The absence of documentation of the events in the ongoing visits was perhaps a fatal error that would have been further exploited at retrial.

Since the emotional trauma for everybody involved in the first trial was an experience nobody wanted to repeat, the physician requested a settlement, if it could be reached for a reasonable amount. This was done, and the agony ended. Nobody was satisfied! Nobody ever is in medical malpractice lawsuits!

This case illustrates the vagaries of the medical malpractice legal system. It also illustrates the necessity of careful, complete documentation of physician-patient encounters during the course of investigating and managing a patient's complaint. ■

*Reprinted from a December 1999 issue of Tennessee Medicine. The Case of the Month is taken from actual Tennessee closed claims. An attempt is made to fictionalize the material in order to make it less easy to identify. If you recognize your own case, please be assured that it is presented solely for the purpose of emphasizing the issues presented.*

# ARKANSAS

## EMERGENCY DEPARTMENT OPPORTUNITIES

### EmCare

Leader in Physician Practice Management

#### BAPTIST MEMORIAL HOSPITAL - BLYTHEVILLE, ARKANSAS

- 16,000 Annual Patient Volume
- 12 Hour Shifts
- New 8 Bed ED
- BP/BC EM or PC
- Relocation Allowance
- Signing Bonus

#### CRITTENDEN MEMORIAL HOSPITAL - WEST MEMPHIS, ARKANSAS

- 17,000 Annual Patient Volume
- 12 Hour Shifts
- 10 Bed ED
- BP/BC EM or PC
- Relocation Allowance
- Signing Bonus

For more information contact: Lisa Clayton @ (800) 362-2731 ext. 2718

Fax C.V. to: (214) 712-2444 or

Email: [Lisa\\_Clayton@EmCare.com](mailto:Lisa_Clayton@EmCare.com)

**The EmCare Mission:** *To serve and support physicians, hospitals, and other healthcare clients in providing high-quality patient care.*

**We Offer Competitive Compensation & Excellent Benefits**

An Equal Opportunity Employer

[www.EmCare.com](http://www.EmCare.com)

## ATTENTION!

### Investment suitable for Profit Sharing/ Professional Funds.

Fully leased medical building in West Little Rock.  
Less than four years old. Approximately 10% return  
on price of \$560,000.

*Contact John or Jeb Burnett*

North Little Rock medical office for lease;  
1,300 square feet.

*Contact Jeb Burnett*

Dental office for lease on  
John F. Kennedy Blvd. in North Little Rock

*Contact Vaughn McQuary*

Rector Phillips Morse

(501) 664-7807

1501 N. University, Suite 800, Little Rock, AR 72207



# CARDIOLOGY



## Tobacco Cessation

**AUTHOR:** LEE DAVIS, MD — **EDITOR:** EUGENE S. SMITH, III, MD

Few interventions are as cost-effective as tobacco cessation, but frequently, practitioners become discouraged by the high relapse rate. The appropriate addition of pharmacotherapy can improve the success rate. This article reinforces an established approach to identifying and assisting our patients addicted to tobacco products and outlines the pharmacologic interventions available to assist them.

There are 46 million tobacco users in the United States, and 435,000 die each year as a result of their use.<sup>1</sup> Tobacco users are at increased risk of developing cardiovascular disease, cancer, hypertension, stroke, respiratory disease and pre-term labor.

As a consequence of chronic tobacco use, an annual \$50 billion is spent directly on medical cost, in addition to the \$47 billion spent indirectly.<sup>2</sup>

Despite adequate education and serious health consequences, most tobacco users find smoking cessation impossible. Seventy percent of tobacco smokers present to their primary-care physicians each year. It's in this setting that the likelihood of smoking cessation can be improved. Physicians today have numerous treatment options for smoking cessation, ranging from drugs to behavioral interventions.

### Smoking Cessation

Spontaneous smoking cessation occurs in 1-2% of tobacco users and increases to 3-5% with physician

encouragement.<sup>3</sup> Usually, 4-5 attempts are needed to achieve smoking cessation.<sup>4</sup> With drug intervention, smoking cessation rates double compared with placebo.<sup>13</sup>

Five drugs have been approved by the FDA for smoking cessation. Nicotine gum was introduced in 1984 and was followed by the nicotine patch in 1994, nicotine spray in 1996, bupropion in 1996 and the nicotine inhaler in 1998.

### Pharmacotherapy

Studies have shown that nicotine gum increases cessation rates at six months by a factor of 1.6-2.8, compared with placebo.<sup>6</sup> It is available in doses of 2mg and 4 mg. Dosing recommendations should be based on the level of tobacco usage.

Dosing of 4 mg is suggested for individuals with a daily usage of more than 24 cigarettes, and 2 mg for less than 24 cigarettes. Nicotine gum can safely be used for six months and is now available only as an over-the-counter prescription.

The highest level of compliance of all the smoking cessation drugs has been shown to be with the nicotine patch. It is available over the counter and as a prescription.

Dosing ranges from 7-21 mg per 24-hour dosing and 15 mg per 16 hours. Usually, the initial patch is used for four weeks, with the wearer tapering off with use of a lower-dose patch over the next four weeks.

The nicotine patch improves

cessation rates, especially in the black and Hispanic population, according to studies. That should be taken into consideration when treating this population of tobacco users.<sup>7,8</sup> Cessation rates at six months for the nicotine patch increase by a factor of 1.6-2.8 compared with placebo.<sup>6</sup>

Local irritation of the throat and mouth is a common adverse effect that many patients report when using the nicotine inhaler. The nicotine inhaler increases cessation rates by a factor of 1.8-3.5 at six months compared with placebo.<sup>6</sup>

The nicotine inhaler is provided in cartridges, with a recommended dosing of 6-16 cartridges per day. It can be used safely for up to six months and only by prescription. The nicotine inhaler mimics regular cigarette use and may also provide an added benefit to those individuals whose tobacco use is a habit as well as an addiction.

The nicotine spray delivers nicotine more rapidly than any other nicotine replacement therapy,<sup>9</sup> producing peak serum levels in 10 minutes.<sup>10</sup> This property makes nicotine spray the drug of choice when the goal is to reduce cravings or withdrawal symptoms acutely.

One-two doses of nicotine spray are suggested each hour. Tobacco users should not exceed 40 doses in 24 hours.

Nicotine spray doubles cessation rates, compared with placebo. There are some reports of nose and eye irritation with frequent dosing.

Bupropion is the only oral non-nicotine replacement therapy approved by

the FDA. The recommended dosage is 150 mg for three days, followed by 150 mg twice a day for 7-12 weeks. Bupropion increases cessation rates by a factor of 1.5-1.7 at six months compared with placebo.<sup>6</sup>

The major side effects of bupropion are insomnia, dry mouth, headaches, and tremors. One of the main contraindications for bupropion is the presence of seizure disorders. But it can be safely combined with any of the nicotine replacement therapies.

Numerous studies have been conducted on various combinations of smoking-cessation drugs. Combinations include nicotine patch-nicotine gum, nicotine patch-nasal spray, and transdermal nicotine patch-bupropion. All showed increase cessation rates compared with monotherapy.<sup>11,12,14</sup>

All therapies should be in conjunction with intensive behavioral interventions. Patients should be provided adjuvant therapies such as counseling, educational materials, social support groups, and smoking cessation clinics. All of the above stated cessation rates were in conjunction with extensive adjuvant therapies.

## Withdrawal Syndrome

Nicotine is the addicting component of tobacco. With smoking cessation, tobacco users develop withdrawal symptoms within 24 hours because of the physiological deficit of nicotine. Tobacco withdrawal syndrome includes depression, irritability, hostility, impatience, headaches, restlessness, anxiety, and cravings.

Relapse peaks within the first seven days and is most commonly caused by withdrawal syndrome.<sup>4</sup>

## The Physician's Role

The U.S. Public Health Service published specific guidelines to identify and treat these patients. Key guideline recommendations are known as the 5A's: ask, advise, assess, assist and arrange.

The first step is to ask and thus identify the tobacco user. Measures should be taken to address tobacco use in each patient presenting to your practice. Once a tobacco user is identified, he or she should be advised to discontinue use.

Advisement is then followed by assessment. Tobacco users' level of

motivation to discontinue tobacco use should be gauged.

Assist all patients with achieving tobacco cessation and set a quit date. If the patient has no desire to discontinue tobacco use, patient education should be initiated. The deleterious effects of continued tobacco use should be explained.

Once a decision to continue or discontinue tobacco usage is made, a follow-up is arranged. The follow-up can be performed by letter, return visit or telephone.

## Conclusion

Smoking cessation is cost-effective, and, depending on the stage of disease, the risk of smoker-induced disease can be improved. All the present FDA-approved smoking cessation drugs are equally efficacious when used correctly.<sup>6</sup> The disadvantages and advantages of smoking-cessation drugs should be used to determine the adequate drug for a tobacco user. Combination therapies should be provided for those tobacco users failing monotherapy. Drug therapies combined with aggressive behavioral interventions improve cessation rates overall.<sup>5</sup>

Smoking cessation can decrease the risk for lung disease, coronary artery disease, hypertension, and stroke.<sup>4</sup> There is no level of safe tobacco use. Every attempt should be made to achieve smoking cessation. ■

*Drs. Davis and Smith are from the division of cardiology, UAMS Medical Center, and the John L. McClellan Memorial Veterans Hospital.*

## References

1. US Department of Health and Human Services. Healthy People 2000. Washington DC: US Government Printing Office; 1991. DHHS publication (PHS)91-50212.
2. Centers for Disease Control and Prevention. Medical expenditure attributable to cigarette smoking—United States, 1993. *MMWR Morb Mortal Wkly Rep.* 1994; 43:925-930.
3. Fiscella K, Franks P. Cost effectiveness of the transdermal nicotine patch as an adjunct to physicians' counseling. *JAMA.* 1996. 275:1247-1251.
4. US Department of Health and Human Services. The Health Benefits of

Smoking Cessation. Washington, DC: Public Health Service, Center for Chronic Disease Prevention and Health Promotion, Office of Smoking and Health; DHHS publication (CDC)90-8416.

5. Shiffman S, Pinney JM, Gitchell J, Burton SL, Lara EA. Public health benefit of over-the-counter nicotine medications. *Tob Control.* 1997. 275:1270-1280.
6. Hughes JR. Combining behavioral therapy and pharmacotherapy for smoking cessation: an update. In: Onken LS, Blaine JD, Boren JJ, eds: Integrating Behavioral Therapies With Medication in the Treatment for Drug Dependence: NIDA Research Monograph. Washington, DC: US Government Printing Office, 1995. 92-109. Monograph 150.
7. Ahluwalia JS, McNagny SE, Clark WS. Smoking cessation among inner-city African Americans using the nicotine patch. *J Gen Intern Med.* 1998. 13:1-8.
8. Leischow SJ, Hill A, Cook G. The effects of transdermal nicotine for the treatment for Hispanic smokers, *Am J Health Behav.* 1996. 20:304-311.
9. Schneider NG, Lunell E, Olmstead RE, Fagerstrom KO. Clinical pharmacokinetics of nasal nicotine delivery: a review and comparison to other nicotine systems. *Clinical Pharmacokinet.* 1996. 31:65-80.
10. Gourlay SG, Benowitz NL. Arteriovenous differences in plasma concentration of nicotine and catecholamines and related cardiovascular effects after smoking, nicotine spray, and intravenous nicotine. *Clin Pharmacol Ther.* 1997. 62:453-463.
11. Fagerstrom KO. Combined use of nicotine replacement products. *Health Values.* 1994. 18:15-20.
12. Blondal T, Gudmundson LJ, Olafsdottir I, Gustavsson G, Westin A. Nicotine nasal spray with nicotine patch for smoking cessation: randomized trial with six-year follow-up. *BMJ.* 1999. 318:285-288
13. Hughes JR, Golstein MG, Hurt RD, Shiffman S. Recent advances in the pharmacotherapy of smoking. *JAMA.* 281(1):72-6. 1999 Jan 6.
14. Jorntby DE, Leischow SJ, Nides MA, et al. A controlled trial of sustained-release bupropion, a nicotine patch, or both for smoking cessation. *N Eng J Medicine.* 1999. 340:340:685-691.



## Reported Cases of Selected Diseases in Arkansas Profile for October 2000

The three-month delay in the disease profile for a given month is designed to minimize any changes that may occur due to the effects of late reporting. The numbers in the table below reflect the actual disease onset date, if known, rather than the date the disease was reported.

Disease Name	Total Reported Cases YTD 2000	Total Reported Cases YTD 1999	Total Reported Cases YTD 1998	Total Reported Cases 1999	Total Reported Cases 1998
Campylobacteriosis	176	142	159	165	179
Giardiasis	149	129	142	153	168
Salmonellosis	573	593	555	698	616
Shigellosis	163	73	194	76	211
Hepatitis A	103	50	79	81	82
Hepatitis B	71	60	103	100	115
Hepatitis C	7	7	7	9	10
Meningococcal Infections	11	32	27	35	31
Viral/Aseptic Meningitis	22	42	69	53	77
Ehrlichiosis	21	21	14	22	14
Lyme Disease	4	4	8	7	8
Rocky Mountain Spotted Fever	19	18	23	25	23
Tularemia	18	16	25	17	26
Measles	0	4	0	5	0
Mumps	1	0	13	0	13
Chlamydia	5,137	5,220	3,201	5,937	4,127
Gonorrhea	3,093	2,825	3,281	3,268	3,962
Syphilis	177	181	267	213	294
Pertussis	31	19	87	26	93
Tuberculosis	169	141	122	181	171

For a complete list of reportable diseases in Arkansas, call the Arkansas Department of Health, division of epidemiology, at (501) 661-2893 during normal business hours.

**G o t  
s o m e  
i s s u e s**

**you'd like  
to see  
addressed  
in**

**The Journal?  
call Natalie  
Gardner at  
(501) 372-1443  
or e-mail**

ngardner@abpg.com.

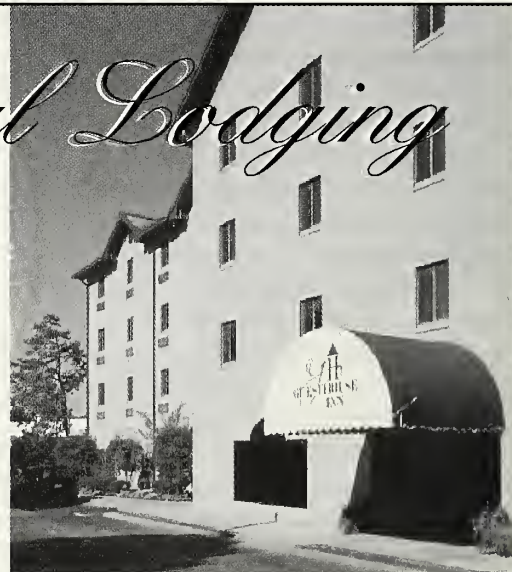
## Medical Lodging

Close proximity to all  
Little Rock hospitals

Serving Little Rock Visitors

- Medical stays
- Business travel
- Leisure travel

"Guesthouse Inn is your  
perfect home away from home  
while in Little Rock"



**GUESTHOUSE**  
Inns • Hotels • Suites

301 So. UNIVERSITY AVE. ▲ LITTLE ROCK, AR 72205 ▲ (501) 664-6800



# The Langston Collection

RICHARD B. CLARK, MD



Fig. 1: Memorial plaque in the library at the University of Arkansas for Medical Sciences.

If one wanders through the library at the University of Arkansas for Medical Sciences on West Markham Street, one will find, on a wall on the first floor, a plaque bearing the likeness of two individuals: William C. Langston Sr. (1890-1977), and William C. Langston Jr. (1919-1943). A memorial book collection is mentioned (Fig. 1). Who were these people? What relation do they have with the College of Medicine? Why is this collection of books dedicated to them?

William Cleaver Langston Sr. was born Jan. 3, 1890, in Newberry County, S.C., the son of a Baptist minister. He graduated from Furman University in 1911 and enrolled in medical school at Wake Forest College.<sup>1</sup> Illness forced him to drop out, and he assumed the direction of a one-teacher school at Nixonville, S.C., where he taught all eight grades.

In 1912, he became the principal of a three-teacher school in the mountain region of North Carolina. From 1914 to 1916, Langston taught physics and biology at the Brewton-Parker Institute in Georgia and received a fellowship in biology at

Middlebury College in Vermont, where he later served as a faculty member.

It is said that during his time as a student, he would sometimes sign up for a class, and if there was no one to teach it, he would teach it himself.<sup>2</sup>

He married Blanche Peacock of Vidalia, Ga., in 1917. Langston served as a first lieutenant in World War I in the 322nd Infantry in the Vosges Mountains and Meuse-Argonne campaigns in France.

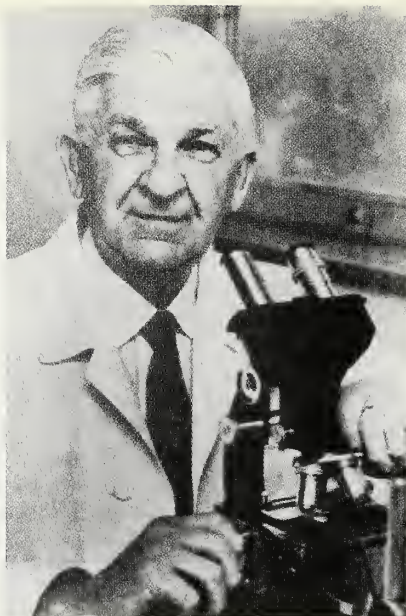
When he returned to the United States, he resumed teaching in Georgia and attended the University of Chicago during the summers.

The Langstons had four children: William C. Langston Jr.; Mary Beth Langston (born in 1920); Franklin Langston (1926-1994); and Robert H. Langston (born in 1931). In 1921, Langston entered the University of Alabama, alternating teaching and attending classes.

In 1926, he went to the State University of Iowa as a teacher/



Fig. 2: ► William C. Langston, 1890-1977. The plaque was dedicated "to the memory of W. C. Langston, MD, who was close enough to God to be truly human. As Professor, Chairman of the Anatomy Department, Acting Dean and Professor Emeritus in his 31 years at the University of Arkansas Medical Center, he related to others with Christian creativity in such a way as to enrich their lives and to help them become truly better people. To his continuous influence for good, this collection is now dedicated by those who called him husband, father, teacher, and friend."



◀ Fig. 3: William "Bill" C. Langston Jr. 1919-1943. The plaque was dedicated "to the memory of Bill Langston who, though having full knowledge of impending death, possessed a secret of living which so revealed him to God, his fellow man, and the world reality about him as to enable him to live the last year of his life purposefully, cheerfully, and wholly without complaint. This collection of books is affectionately dedicated by his classmates and fellow students of the University of Arkansas School of Medicine."

student and, after eight years of part-time school, was awarded his medical degree.

He remained at Iowa for another year before coming to Arkansas in 1930. While in Arkansas, he conducted research with Dr. Paul Day on Vitamin M (folic acid). Dr. Langston became head of the Anatomy Department in 1941 and was acting dean of the school from 1948-50.

He was asked to assume the position of permanent dean but preferred his role as chairman of anatomy.<sup>3,4</sup>

This writer found Dr. Langston to be a dedicated teacher with a sense of humor. One day, while musing on the teaching of anatomy, he pointed out that although very small, some structures become very important when they malfunction — for example, the Canal of Schlemm. He was an excellent, enthusiastic and somewhat bombastic teacher, continually drawing multidimensional sketches on the blackboard with different colors of chalk while lecturing at a rapid pace.<sup>5</sup>

We students called him "Silver Bill," but never to his face. It was only recently that I learned that his preferred nickname was "Clea."

Dr. Langston and his family developed a fondness for the Buffalo River in north Arkansas, and, nearly every summer, they rented a cabin at Pruitt, on the banks of the Buffalo, subsisting on fish caught in the river and on chickens and produce purchased from local farmers. These experiences strongly influenced his children.

Dr. Langston retired in 1957<sup>1</sup> (Fig. 2). He continued to work part time in the department and died in 1977. He was buried in

Roselawn Cemetery in Little Rock. His many years of teaching Sunday school honored the values of his father.<sup>5</sup>

William C. Langston Jr. was born in 1919 in Vidalia, Ga. He moved to Little Rock with his family in 1930 and attended Little Rock High School. He attended the State University of Iowa for three years (1937-40) and applied for admission to the University of Arkansas School of Medicine (the School of Medicine became the College of Medicine in 1975)<sup>3</sup> (Fig. 3). He was accepted and entered the freshman class in the fall of 1940.

Bill's progress was satisfactory, but, after a time, he began to suffer from headaches and then developed seizures. A brain tumor was suspected, and he traveled to the Mayo Clinic, in Rochester, Minn., for a second opinion. The diagnosis was confirmed, and he returned to Little Rock for surgery, as a young, energetic neurosurgeon had arrived in Little Rock.<sup>2</sup>

This was Dr. Robert Watson, the first neurosurgeon in Arkansas. Surgery was performed at University Hospital (which was then at 12th and McAlmont). The diagnosis was astrocytoma, and the surgery was not successful.

Langston lingered for some time postoperatively but never regained consciousness. He died on Nov. 22, 1943, and was buried in Roselawn Cemetery.

One can imagine the devastation that overwhelmed the Langston family at Bill's death.<sup>6</sup> He was in his junior year in medical school. His nickname, "Bill," appears on his tombstone. He was a remarkable person, especially during the terminal months of his illness. He was an avid reader and a committed Christian. It was decided that a suitable memorial for the young Langston would be a collection of books, as both he and his parents loved learning.

A trust fund was begun and the collection started, to honor "one who had died while learning the art of Aesculapius." The idea was to purchase and keep together books not directly about medicine, but related to general subjects, such as philosophy and travel, particularly religion and medicine.

The scope of the Langston Book Collection was defined as "spiritual in connotation, relating to the study and practice of medicine — including morality, compassion and the humanness in the Judeo-Christian philosophy — with a view to broadening the sciences in service to his fellow man, and his relationship to God."

A small alcove was eventually developed where students could sit and read for enjoyment. When the elder Langston died in 1977, the present plaque was installed, with both pictures on it (Fig. 1).

Robert H. Langston was born in 1931 in Little Rock and attended Little Rock High School, graduating in 1949. He attended the University of Arkansas at Fayetteville and was admitted to medical school after three years of premedical study. He graduated with a medical degree in 1956.

Robert Langston recalls that his father treated him as he did



the other students.<sup>2</sup> He married Frances Simpson in 1953. Langston interned at Baptist Hospital in Little Rock and then went into the Army, being stationed at Fort Chaffee and at the Pine Bluff Arsenal.

In 1960, he entered family practice in Harrison with Dr. Albert Hammon (with whom he had preceptored). Dr. Langston



Fig. 4  
Robert Langston, MD

had a busy practice in Harrison until he retired in 1996. He is active in the Baptist Church, North Arkansas Community College and the Arkansas Medical Society (Fig. 4).

Robert and Frances Langston had three children:

William Robert (born in 1956), James David (born in 1958) and Thomas Albert (born in 1962).

James Langston attended the University of Arkansas at Fayetteville and graduated from the College of Medicine in 1988. He completed a residency in general surgery in 1993 at UAMS and has an active practice of surgery in Harrison with Dr. Tom Bell<sup>1</sup> (Fig. 5). He married Pamela Thompson in 1986 and they have two children: Jacob (born in 1990) and Jillian (born in 1992).

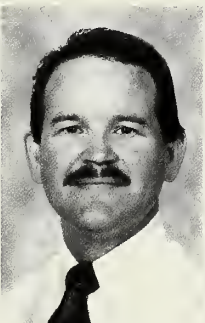


Fig. 5  
James Langston, MD

Dr. Thomas Langston joined his father's practice in 1990. He attended the University of Arkansas at Fayetteville and graduated from the College of Medicine in 1987. His residency in family practice was at Washington Regional Medical Center in Fayetteville.<sup>8</sup> He married Cindy Lowe in 1983 and they have three children: Nicholas (born in 1988), Rebekah (born in 1991) and Maggie (born in



Fig. 6  
Thomas Langston, MD

*A constant reminder  
that you can be  
both beautiful  
and strong.*



**ROLEX**

*Official Rolex Jeweler*  
**MARY HEALEY'S**  
**FINE JEWELRY**

*Because You Love the Best  
For Those You Love*

5600 Kavanaugh • Little Rock, AR 72207  
501-661-1314 • 501-661-9368 Fax  
Mon-Sat 10 am-5:30 pm

B u y — S e l l — L e a s e — R e n t



The MedPlus Group is a B2B website that helps medical facilities find the best prices available on New, Used, and Refurbished medical equipment. With over 500 dealers, suppliers and manufacturers to select from, we have the solutions to meet your needs. In addition, we offer our customers flexible lease options to finance their purchase. Visit us on-line today or call Mike South or Rick Wooldridge for more information.



**MedPlusQuotes**

**Healthcare Resources**

(800) 643-0944 Fax (501) 224-0930  
www.medplusquotes.com email: info@medplusquotes.com





*HEALTH  
DATA  
SERVICES,  
LLC*

*a medical information  
management company*

An independent medical  
transcription company  
providing services  
to small practices,  
large clinics, and  
hospital overflow  
throughout Arkansas.

### **DO YOU SUFFER FROM TRANSCRIPTION OVERLOAD?**

350 Salem Road, Suite 6C • Conway, AR 72032  
Phone: (501) 327-7077 • Fax: (501) 327-8588  
Email: [hdsllc@cyberback.com](mailto:hdsllc@cyberback.com)

## *Medical Practice Consultants, Inc.*

**An Arkansas-Based Firm with Over 75 Years  
of Medical Practice Knowledge**

- **Custom-Designed Compliance Program**
- **Coding and Documentation Evaluations**
- **Practice Assessments With Reports**

**Call 1-870-236-1899  
for information on affordable services  
designed to meet YOUR medical practice needs**

**M P C**

Donald B. Smith — CEO  
Benjamin "Mac" Butler — Consultant  
Patty Pendergrast — Consultant

1995). He practices medicine at the Family Doctors Clinic in Harrison, the facility his father built (Fig. 6).

The Langston Book Collection is no longer kept together at the library. Some years ago, the books were distributed throughout the library collection, according to their classification, to make them more accessible and to promote their use. Although they are not now kept together as a collection, a memorial book plate identifies each of the books "In memory of Bill Langston and Dr. W.C. Langston." There is still a fund for purchase of books for the Langston Collection.

The Langston name is well known and respected in Arkansas. Thus the term "Langston Collection" applies both to the collection of books in the UAMS Library and to this medical family, which has produced three generations of caring, dedicated physicians. Their story should be an inspiration to current and future physicians.

Will there be a fourth generation? The Langston great-grandchildren are too young at this writing to make a commitment, but it remains a possibility. ■

*Dr. Clark is a professor emeritus in the departments of anesthesiology and obstetrics/gynecology at the University of Arkansas for Medical Sciences.*

#### **References**

1. Obituary: Dr. W.C. Langston, Sr., Arkansas Gazette, April 21, 1977.
2. Robert H. Langston, MD: Personal interview on May 25, 2000.
3. Baird, W. David: Medical Education in Arkansas, 1879-1978, 1979, Memphis State University Press, p. 201.
4. Marvin, Horace N: Anatomy in Arkansas' Medical College 1879-1979, *The Journal of the Arkansas Medical Society*, 77:253-264, 1980.
5. Bruce, Thomas A., MD: Medical School Deans, in *Historical Perspectives*, edited by Max L. Baker, PhD. The College of Medicine at the Sesquicentennial, 1986, pages 45-46.
6. Obituary: W.C. Langston, Jr., Arkansas Gazette, Nov. 23, 1943.
7. James Langston, MD: Personal interview on May 25, 2000.
8. Thomas Langston, MD: Personal interview on May 25, 2000.

# PEOPLE + EVENTS

## HONORED

### **Dr. Haynes Elected to Wildlife Society**

Dr. W. Ducote Haynes, a retired Searcy physician, has been elected president of the Arkansas Wildlife Federation, a nonprofit hunting, fishing and conservation organization.

Dr. Haynes graduated from the University of Arkansas at Fayetteville and received his medical degree from the University of Arkansas for Medical Sciences. He took a fellowship at the M.D. Anderson Cancer Center in Houston, specializing in radiation oncology.

In 1976, Dr. Haynes was named the first chief of staff at the Central Arkansas Radiation Therapy Institute. He practiced at the Little Rock CARTI location until becoming medical director of CARTI in Searcy in 1988. He retired in 1996.

### **Student Group Honored Nationally**

The Arkansas Medical Society Medical Student Section (AMS-MSS) won national honors at the American Medical Association's annual meeting in Chicago in June. The medical students were recognized for having the greatest number of students per capita who were organ donors.

The award was presented as the AMA Medical Student Section concluded its 1999 national community service project, Organ Donor Awareness.

The 2000 national com-

munity service project is called the Children's Health Insurance Program. Rebekah Craig-Nunez, a second-year medical student at the University of Arkansas for Medical Sciences, is the committee chairman.

The students are conducting a statewide outreach program for ARKids First and attempting to educate and sign up as many children and families for the program as possible.

### **Dr. Strode Appointed to Review Committee**

Dr. Steven Strode of the University of Arkansas for Medical Sciences has been appointed to a three-year term on the Committee for Review and Recognition of the Accreditation Council for Continuing Medical Education, based in Chicago.

The CRR surveys, evaluates and recognizes medical societies to accredit intrastate providers of CME. It also recommends policy and actions relevant to recognition to the Council.

### **Physicians Receive Awards from AMA**

Each month the American Medical Association presents the Physician's Recognition Award to those who have completed acceptable programs of continuing education.

AMA recipients for October are Dr. Joe D. Hester of Magnolia, Dr. Sandra M. Johnson of Little Rock, Dr. Narayan-

swami Rangaswami of Helena and Dr. Dowling B. Stough of Hot Springs.

### **Dr. Smith Named 'Community Pioneer'**

Dr. Floyd A. Smith Jr. of Trumann was honored as a "community pioneer" at the annual Wild Duck Festival on Oct. 6-7 in Trumann. Dr. Smith served as grand marshal of the Wild Duck Festival Parade and was honored at a reception.

## OBITUARIES

### **Charles Anderson, MD**

Dr. Charles Anderson, 91, of Pine Bluff, died Oct. 5. Dr. Anderson graduated from Emory University Medical School in 1935 and interned at Marine Hospital in New Orleans.

He served in public health service in Miami from 1936-37 and then joined the Army Medical Corps. He continued his education at the New York City Cancer Institute and Bellview Hospital, specializing in radiology.

When called to active duty in 1941, Dr. Anderson became radiology consultant for the 15th Army Medical Center in England. He retired as a lieutenant colonel in 1946 and practiced radiology in Pine Bluff until his retirement in 1977. He was a founding partner of Pine Bluff Radiology Associates and was a past director of the Southeast Arkansas Tumor Clinic.

He was preceded in death by his wife, Marion Robson,

and two sons, James Anderson and William Anderson. He is survived by a daughter, Nancy Marion Hillman of Cabot; three sisters; and several grandchildren.

### **William 'Bill' Garner, MD**

Dr. William "Bill" Garner, 71, of Jonesboro, died Nov. 12. He was a retired radiologist.

Survivors include his wife, Jackie Garner; daughter, Jackie Perdew; two sons, Bill Garner Jr. and Dr. Matt Garner; a brother, Judge Harry R. Garner; and nine grandchildren.

### **James S. Garrison, MD**

Dr. James S. Garrison, 62, of Conway, died July 31. He was retired. Dr. Garrison graduated from UAMS in 1964 and was an AMS member since 1971.

### **Ernest Lee Hutchison Jr., MD**

Dr. Ernest Lee Hutchison Jr., 82, of Heber Springs, died Nov. 6. He was a graduate of Hendrix College. Dr. Hutchison helped found the Jefferson Hospital in Pine Bluff, where he practiced medicine for 30 years. He was a veteran of the Navy, having served in the Pacific during World War II.

Survivors include his wife, Sharollette Hutchison of Heber Springs; a son, E. Lee Hutchison III of Memphis, Tenn.; two daughters, Ann Love of Springdale and Susan Wells of Nome, Alaska; a sister, Frances Harris of Richmond, Va.; and six grandchildren.



**William Ray Keadle, MD**

Dr. William Ray Keadle, 73, of Glenwood, died Nov. 16. He was a graduate of Hendrix College and the University of Arkansas Medical School. He is preceded in death by his brother, Randall Keadle, and his son, James Ray Keadle.

Dr. Keadle is survived by his wife, Alice Louise Keadle; two daughters, Debra Ann Cowart of Glenwood and Karen LaDonne Hall of Klamath Falls, Ore.; two sons, William Edward Keadle and Gary Wayne Keadle, both of Little Rock; a sister, Ruth Tolbert of Point Cedar; a brother, James Ray Keadle of Texas; and four grandchildren.

**J.F. Kelsey, MD**

Dr. J.F. Kelsey, 78, of Fort Smith, died Nov. 5. He was a graduate of Kansas

University School of Medicine and was certified by the American Board of Obstetrics and Gynecology. Dr. Kelsey practiced medicine in Fort Smith with Obstetric and Gynecology Associates from 1953 until his retirement in 1986. He was an Army veteran of World War II and the Korean War.

He was elected to the Alpha Omega Alpha honorary medical society and was a member of the American Medical Association. He was a past president of the Sebastian County Medical Society and the Southeastern Obstetrical and Gynecological Society, and a fellow and past chairman of the Arkansas section of the American College of Obstetricians and Gynecologists. He served on the staff of Sparks Regional Medical Center

and St. Edward Mercy Medical Center and was an associate clinical professor of the University of Arkansas for Medical Sciences.

He is survived by two

daughters, Margo Roberts of Dodge Center, Minn., and Ellen Jacobi of Grand Forks, N.D.; a son, Dr. Fred C. Kelsey of Fairfax, Va.; and eight grandchildren. ■

**New Members****David Fort Jr., MD**

Specialty: Resident-FP  
601 W. Maple Ave., #102  
Springdale, AR 72764  
(501) 750-6585

**Jason A. Franks, MD**

Specialty: Resident-IM  
4719 N. Lookout  
Little Rock, AR 72205

**John Frino, MD**

Specialty: Resident-ORS  
4301 W. Markham St., #531  
Little Rock, AR 72205  
(501) 686-5110

**Robert Garcia, MD**

Specialty: FP  
306 N. Alabama  
Crossett, AR 71639  
(870) 364-4181

**Martha G. Garrett-Shaver, MD**

Specialty: Resident-FP  
460 W. Oak St.  
El Dorado, AR 71730  
(870) 862-2489

**Caleb O. Gaston, MD**

Specialty: Resident-FP  
612 S. 12th St.  
Fort Smith, AR 72901  
(501) 785-2431

**Glenn G. Gibbons, MD**

Specialty: Resident-FP  
612 S. 12th St.  
Fort Smith, AR 72901  
(501) 785-2131

**Charles C.****Glendenning, DO**

Specialty: FP  
P.O. Box 130  
Spiro, OK 74959  
(918) 962-2442

**Let Us Hear From You!**

You can now e-mail AMS  
at the following addresses:

Main address:

[ams@arkmed.org](mailto:ams@arkmed.org)

Ken LaMastus:

[klamastus@arkmed.org](mailto:klamastus@arkmed.org)

Lynn Zeno:

[zeno@arkmed.org](mailto:zeno@arkmed.org)

David Wroten:

[dwroten@arkmed.org](mailto:dwroten@arkmed.org)

Kay Waldo:

[kwaldo@arkmed.org](mailto:kwaldo@arkmed.org)

Journal:

[journal@arkmed.org](mailto:journal@arkmed.org)



Plus... Visit our web site at:

[www.arkmed.org](http://www.arkmed.org)

**UAMS****continuing  
medical  
education**

Office of Continuing Medical Education...

**Committed to Life-Long Learning**

**2001 Programs****Feb. 9-10 Geriatric Medicine Update**

Location: The Holiday Inn Select, Little Rock, AR

**Mar. 2-3 Neurology for the Non-Neurologist**

Location: UAMS Pauly Auditorium, Ed III Bldg.

**Mar. 11-16 Annual Conference of the UAMS-Prosper Meniere Society**

Location: Inn at Aspen, Aspen, CO

**Mar. 21-24 Southern Group on Educational Affairs**

Location: Excelsior Hotel, Little Rock, AR

**Apr. 5-7 Symposium on Critical Care and Emergency Medicine**

Location: Arlington Resort Hotel, Hot Springs, AR

Joint Sponsors: UAMS and Univ. of Tennessee

**Mar. 17 Symposium on Sleep Disorders**

Location: UAMS/ACRC Walton Auditorium

**Apr. 25 Best Practices in the Continuum of Care**

Location: DoubleTree Hotel, Little Rock, AR

**May 5 W.W. Stead Chest Symposium**

Location: The Austin Hotel, Hot Springs, AR

**May 11 The Diamond Conference**

Location: The Riverfront Hilton Inn, North Little Rock, AR

**May 18 The Diabetes Update 2001**

Location: The Holiday Inn Select, Little Rock, AR

**For additional information,**

**call the Office of Continuing Medical Education at (501) 661-7962  
or check out our website, [www.uams.edu/cmefd/cme2.htm](http://www.uams.edu/cmefd/cme2.htm)**





## Downtown Little Rock

Those who have not visited Little Rock recently will certainly be surprised by the rapid and dramatic changes made downtown. Once a lonely, quiet area with little to offer, downtown Little Rock has come alive with restaurants, night spots, museums and specialty shopping.

The River Market provides a place to purchase everything from fresh seafood and homemade pasta to gourmet coffee and barbecue. A Farmers' Market, held Tuesdays and Saturdays, offers homegrown goodies.

During the holiday season, the River Market is turned into a winter wonderland with an open-air ice-skating rink and a light display.

Visitors can enjoy nightlife at the Underground Pub, the Pour House Bar and Grill, The Flying Saucer or Sticky Fingerz, among others. For children, there is the Museum of Discovery, featuring hands-on science and learning exhibits.

Lodging is not a problem downtown. The Excelsior, the Capitol Hotel and the DoubleTree Hotel each offer luxury accommodations for business or pleasure.

Art lovers will delight in the newly expanded Arkansas Arts Center, while history buffs can look forward to the reopening April 28 of the Arkansas Territorial Restoration, with its new 45,000-SF museum center featuring galleries, a restaurant, a gift shop and more.

For more information about Little Rock's attractions, call the Little Rock Convention and Visitors Bureau at (501) 376-4781 or visit [www.littlerock.com](http://www.littlerock.com). ■



Photos: Kirk Jordan



# ADVERTISERS INDEX

AMS Benefits Inc. ....	Inside back cover
Arkansas Financial Group Inc., The .....	268
Arkansas Foundation for Medical Care .....	264
Arkansas Heart Hospital .....	276
Asti, William Henry, AIA .....	275
Autoflex Leasing .....	263
Central Flying Service .....	278
Davis Properties .....	268
EmCare .....	279
Farmers Insurance Group .....	278
GuestHouse Inn .....	282
Health Data Services, LLC .....	286
Maggio Law Firm .....	276
Mary Healey's Fine Jewelry .....	285
MedPlus Quotes .....	285
Medical Practice Consultants Inc. ....	286
Micheal Munson, A.G. Edwards & Sons Inc. ....	266
PhyAmerica Physician Services Inc. ....	290
Professional Advocates .....	Inside front cover
Rector Phillips Morse .....	279
St. Vincent Health System .....	275
State Volunteer Mutual Insurance Co. ....	Back cover
University of Arkansas for Medical Sciences .....	288

Special Publications  
Publisher  
*Brigette Williams*

Special Publications  
Editor-in -Chief  
*Natalie Gardner*

Copy Editor  
*Donna Schratz*

Editorial Assistant  
*Susan Van Dusen*

Sales Manager  
*Stephanie Hopkins*

Account Executives  
*Jason Carson*  
*Liz Earlywine*

Director of Design  
and Circulation  
*Virgeen Healey*

Director of Marketing  
*Allison Pickell*

© 2001 Arkansas Business Publishing Group  
[www.abpg.com](http://www.abpg.com)

Production and Circulation  
Coordinator  
*Jeremy Henderson*

Editorial Art Director  
*Irene Forbes*

Advertising Coordinator  
*Kristen Heldenbrand*

Marketing Assistant  
*Mitzi Tiffie*

Database Administrator  
*Andrea Martin*

Advertising Assistant  
*Greg Duszota*



Chairman & Chief Executive Officer  
*Olivia Farrell*

President and Publisher  
*Jeff Hankins*

Executive Vice President  
*Sheila Palmer*

## Get Published!

Give something back  
to your profession...  
write an article for



*The Journal* needs your thoughts and ideas. So why not consider putting your expertise and experience on paper?

The Arkansas Medical Society is a statewide organization that represents all physicians, regardless of location or type of practice.

The result is a statewide network united for the common good of the medical profession. The staff of the Arkansas Medical Society provides members with the best information and services available.

For information about submitting an article to *The Journal of the Arkansas Medical Society*, call Judy Hicks at 501-224-8967 or 1-800-542-1058.



# PhyAmerica

Physician Services, Inc.

## WALNUT RIDGE, ARKANSAS EMERGENCY MEDICINE OPPORTUNITIES

Director Position Now Available!

- ❖ Seeking BC/BP Physicians for Directorship, and
- ❖ BC/BP Physicians or Third Year Residents w/ EM or PC Specialty for Staff Positions.
- ❖ ACLS Required; Annual Volume: 7,500.
- ❖ Primary & Supplemental Coverage needed.
- ❖ 15 Minutes NW of Jonesboro, AR and 1 hour NW of Memphis, TN.
- ❖ Procured Liability Insurance, IC status, no restrictive covenants.

For more information, contact *Physician Recruiter*,  
**Traci Mahlmeister, 800-476-5986**  
fax 919-382-3274 or e-mail [tmahlmei@phyamerica.com](mailto:tmahlmei@phyamerica.com)  
**PhyAmerica Physician Services, Inc.**  
**2828 Croasdaile Drive, Durham, NC 27705**



# Arkansas Medical Society Insurance Programs....



## **AMS BENEFITS, INC.**

A wholly owned subsidiary of the  
Arkansas Medical Society

P.O. Box 55088

Little Rock, Arkansas 72215-5088

(501)224-8967

WATS 1-800-542-1058

FAX (501) 224-6489

"Available products include group  
health, office package, professional  
liability, home, auto, and more."

*tailor-made for physicians*

Insurance products are a fact of life. You can buy them almost anywhere. Fortunately there's one agency that only represents physicians...Arkansas physicians. AMS Benefits, with products to meet both your professional and personal needs.

Call us at 1-800-542-1058 or 501-224-8967





*There's nothing fair about treating physicians like fair game*

**S**ome folks seem to think that taking pot shots at physicians is just good clean fun. We couldn't agree less. For 25 years, the physicians who operate SVMIC have dedicated themselves to providing the very best protection possible against medical malpractice litigation. As doctors, we know just how dangerous and unfair the world really can be. And, with our unrivaled risk management programs, no one can do more to prevent a physician from ever finding himself in the line of fire, than SVMIC.

For more information, contact Susan Decareaux or Thad DeHart • P.O. Box 1065 Brentwood, TN 37024-1065  
e-mail: [svmic@svmic.com](mailto:svmic@svmic.com) • Web Site: [www.svmic.com](http://www.svmic.com) • 1-800-342-2239 • (615) 377-1999



State Volunteer  
Mutual Insurance  
Company



# THE Journal

OF THE ARKANSAS MEDICAL SOCIETY

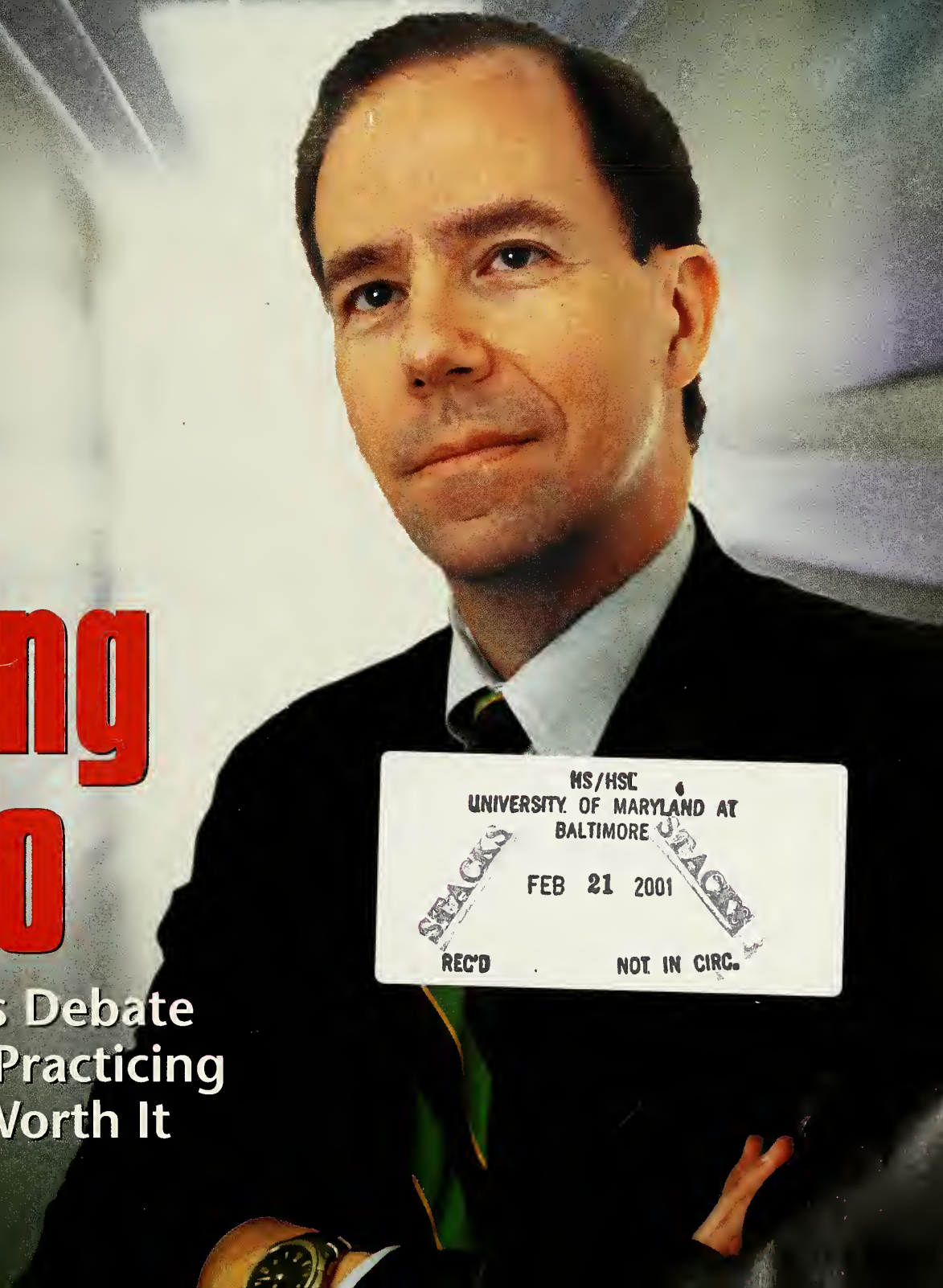
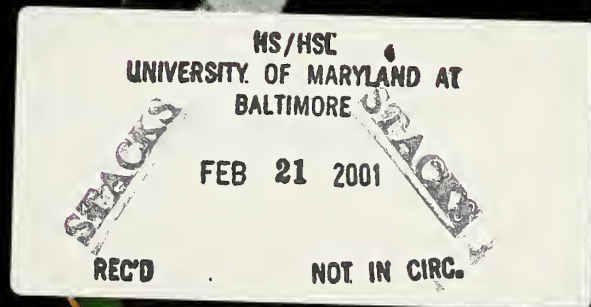
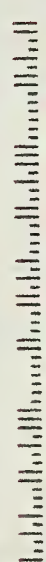
Vol. 97 No. 9

March 2001

Coming  
to

ns Debate  
r Practicing  
Worth It

\*\*\*\*\*MIAMI AD 840 S&A P8  
Health Sciences Library  
University of Maryland  
Collection Development Dept.  
601 W LOMBARD ST  
BALTIMORE MD 21201-1512





# ***RISING TO THE CHALLENGE***

AFMC'S EIGHTH ANNUAL QUALITY CONFERENCE

- ▲ **Clinical Priorities**
- ▲ **Quality Improvement**
- ▲ **Patient Safety**
- ▲ **Public Policy**
- ▲ **Long-Term Care**
- ▲ **Compliance Issues**



## **Speakers Include Local and National Experts**

### **Including John Nance**

- ▲ *New York Times* best-selling author
- ▲ "Good Morning America" Aviation Editor
- ▲ Airline Pilot
- ▲ Board member, National Patient Safety Foundation

**WATCH YOUR MAIL  
FOR REGISTRATION  
MATERIAL!**

For More Information Call AFMC (501)649-8501 ext 204



ARKANSAS FOUNDATION FOR MEDICAL CARE



*There's nothing fair about treating physicians like fair game*

**S**ome folks seem to think that taking pot shots at physicians is just good clean fun. We couldn't agree less. For 25 years, the physicians who operate SVMIC have dedicated themselves to providing the very best protection possible against medical malpractice litigation. As doctors, we know just how dangerous and unfair the world really can be. And, with our unrivaled risk management programs, no one can do more to prevent a physician from ever finding himself in the line of fire, than SVMIC.



State Volunteer  
Mutual Insurance  
Company

For more information, contact Susan Decareaux or Thad DeHart • P.O. Box 1065 Brentwood, TN 37024-1065  
e-mail: [svmic@svmic.com](mailto:svmic@svmic.com) • Web Site: [www.svmic.com](http://www.svmic.com) • 1-800-342-2239 • (615) 377-1999



Two of the best financial planners in the nation are in Arkansas.

They can be found at The Arkansas Financial Group.

**CINDY CONGER**  
MBA, CPA/PFS, CFP

**RICK ADKINS**  
MBA, CFP, ChFC



Since 1985, we've been helping busy people make smart financial decisions. So next time you're looking for objective answers to life's crucial financial decisions, call The Arkansas Financial Group. You'll be in great company.

Here's what the editors of *Worth* and *Medical Economics* had to say:

*"The Best 150 Financial Advisers for Doctors, 8/00"*

*"The Best 250 Financial Advisers, 9/99"*

*"The Best 300 Financial Advisers, 9/98"*

*"The Best 250 Financial Advisers, 10/97"*

*"The 120 Best Financial Advisers for Doctors, 7/27/98"*

*"Fee-only, objective, customized, comprehensive, affordable advice"*

**The Arkansas  
Financial Group, Inc.**  
**376-9051**

PHOTO: KELLY QUINN/TERRITORIAL RESTORATION

**SUCCESS**

**Prestige**

**Fantastic Tax  
Savings**

**VALETS WILL WORSHIP YOU**

**No Luxury Tax**

**Power**

**Fiser  
HUMMER®**

**2001 HUMMERS  
In Stock**

**Hummers are our ONLY Business**  
**1.800.776.4069 • 501.847.9043**  
[www.fiser.com](http://www.fiser.com)

**Special Sale on  
2000 Models**

2000 Red Soft Top  
2000 Yellow Soft Top  
2000 Green Soft Top  
2000 White Soft Top  
2000 Black Hard Top  
2000 Pewter Wagon

**Pre-Owned**

'95 Silver Wagon, Diesel  
'96 Red Soft Top, Diesel  
'97 Yellow Soft Top, Diesel  
'98 Red Wagon/Tan  
'98 White Wagon/Tan  
'99 Red Hard Top/Grey



# CONTENTS

## FEATURES

### 302 Merger Madness — Solo vs. Group Practices

*In the past 10-15 years, solo practices have slowly begun to disappear, largely because of managed care. In response, doctors have banded together to form large group practices. Still, some physicians would rather practice on their own. The Journal examines the advantages and disadvantages of being in group and solo practices.*

### 305 Raising the Bar

*There's no limit to what Heather Diemer, 26, of Little Rock, a medical student and Arkansas Medical Society member, can accomplish. She has high hopes of becoming a family doctor, with an emphasis on adolescent medicine, and a public health advocate. But those are just a few of her goals.*

### 315 Study on Older Female Inpatients in Arkansas

*Our special article examines whether there are significant relationships between age, MDC, mortality, severity of illness, risk of mortality and length of stay in women over 50 who are inpatients in private, nonprofit Arkansas hospitals.*



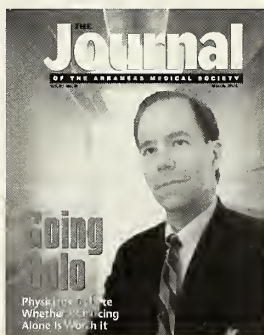
Bill Greene, CEO of OrthoArkansas, sees the many benefits of large group practices.— page 302



The most frequent "problem" area in older female patients is the circulatory system.— page 315

## DEPARTMENTS

- 299 Commentary  
Sue Chambers, MD
- 301 What We've Done  
For You Lately
- 311 Case of the Month
- NEW** 307 A Closer Look at Quality
- 319 People + Events
- 321 Arkansas Retreats
- 322 Index to Advertisers



**On the Cover:** Dr. Joseph Beck, a Little Rock medical oncologist, proves that having a solo practice can be done, even though others have a different opinion.

Cover Photo: Mark Wilson





#### COMMUNICATIONS COORDINATOR

Judy Hicks

#### EXECUTIVE VICE PRESIDENT

Kenneth LaMastus, CAE

#### ASSISTANT EXECUTIVE VICE PRESIDENT

David Wroten

#### EDITORIAL BOARD

Sue Chambers, MD	Pediatrics
Joseph M. Beck, II, MD	Oncology
Lee Abel, MD	Internal Medicine
Samuel Landrum, MD	Surgery
Jerry Kendall, MD	Family Practice
William Ackerman, MD	Anesthesiology

#### EDITOR EMERITUS

Alfred Kahn Jr., MD

#### ARKANSAS MEDICAL SOCIETY

#### 2000-2001 OFFICERS

Gerald A. Stolz, Jr., MD, Russellville  
*President*

Joe Stallings, MD, Jonesboro  
*President-elect*

Paul A. Wallick, MD, Monticello  
*Vice President*

Lloyd G. Langston, MD, Pine Bluff  
*Immediate Past President*

Carlton L. Chambers, III, MD, Harrison/Little Rock  
*Secretary*

Dwight M. Williams, MD, Paragould  
*Treasurer*

Anna Redman, MD, Pine Bluff  
*Speaker, House of Delegates*

Kevin Beavers, MD, Russellville  
*Vice Speaker, House of Delegates*

Joseph M. Beck, II, MD, Little Rock  
*Chairman of the Council*

Established 1890. Owned and edited by the Arkansas Medical Society and published under the direction of the Council.

**Advertising Information:** Contact Stephanie Hopkins, P.O. Box 3686, Little Rock, AR 72203; (501) 372-2816.

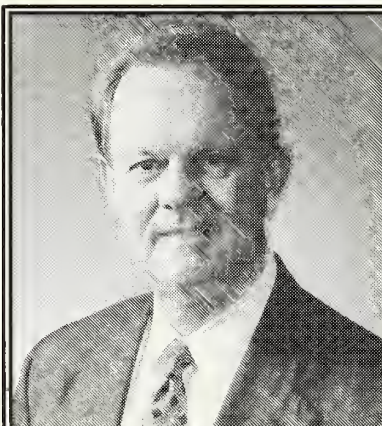
**Postmaster:** Send address changes to: *The Journal of the Arkansas Medical Society*, P. O. Box 55088, Little Rock, Arkansas 72215-5088.

**Subscription rate:** \$30.00 annually for domestic; \$40.00, foreign. Single issue \$3.00.

**The Journal of the Arkansas Medical Society** (ISSN 0004-1858) is published monthly by the Arkansas Medical Society, #10 Corporate Hill Drive, Suite 300, Little Rock, Arkansas 72205. Printed by The Ovid Bell Press, Inc., Fulton, Missouri 65251. Periodicals postage is paid at Little Rock, Arkansas, and at additional mailing offices.

Articles and advertisements published in *The Journal* are for the interest of its readers and do not represent the official position or endorsement of *The Journal* or the Arkansas Medical Society. *The Journal* reserves the right to make the final decision on all content and advertisements.

Copyright 2001 by the Arkansas Medical Society.



Michael McBryde  
Senior Vice President  
& Trust Division Manager

## We provide trust services from right here at home.

Our Trust Division, led by Senior Vice President Michael McBryde, provides personal, corporate and employee benefit trust services from our bank's headquarters in Little Rock. We provide personal, one-on-one service, and we work with all sizes of trusts.

So whether your trust needs are for planning an estate, reviewing a will, developing a retirement account or selecting a trustee, please consider Metropolitan National Bank's Trust Division. Call us at 501-377-7650.



**Metropolitan  
National Bank**

**World Class Banking. Nearby & Neighborly.**

Little Rock, North Little Rock, Sherwood, Benton, Bryant, Conway  
[www.metbank.com](http://www.metbank.com)





## AMS Efforts Defend Children's Health Care

SUE CHAMBERS, MD

**B**ecause a large number of Arkansas children are eligible for Medicaid, the physicians who care for them have a vested interest in keeping the Arkansas Medical Society alive and functioning.

Federal law guarantees Medicaid recipients equal access to health care.

On that basis in 1992, the AMS sued the state Department of Human Services over severe cuts in Medicaid reimbursements that lowered the number of physicians willing to take Medicaid patients. AMS won the decision and a court decree that DHS must negotiate all fees for Medicaid services with the AMS.

Arkansas' Medicaid package for children and pregnant women is one of the best in the nation. Because reimbursement is reasonable and prompt, most physicians in the state are happy to accept Medicaid patients.

When Bill Clinton was elected president, the new governor, Jim Guy Tucker, discovered that Medicaid was operating with a large deficit. By proposing and shepherding the "soda pop tax," the AMS, along with other interested groups, lobbied the Legislature and prevented a 2% tax on hospitals' and physicians' gross revenue, which was how the governor wanted to make up the deficit. This means that a physician generating \$300,000 per year in gross revenue is saving \$6,000 per year in taxes, thanks to the AMS. You do the math; AMS dues are only \$400.

Negotiations with DHS have secured payments of at least 65% of the old Blue Shield allowable for adult Medicaid patient care and 75% for care given to children and pregnant women.

In 1997, neonatologists were given a large boost when the AMS took action against DHS for pricing three new procedure codes pertinent to neonatology way below the agreed-upon rates. The Legislature forced DHS to reprice them, effectively doubling the rates for Arkansas neonatologists who care for large numbers of Medicaid-eligible, sick newborns.

Last year, DHS decided to contract out all mental health services to an entity called Value Options. By doing that, the agency divested itself of responsibility for setting fees. Value Options attempted to contract with psychiatrists and psychologists who would agree to fees about 30% below the old Medicaid fees.

Mental health problems include AD/HD, autism, nocturnal enuresis and behavioral problems such as school phobia. Primary-care physicians could continue care for these illnesses, but they would be paid at the reduced rate. AMS filed contempt-of-court charges, and DHS was forced to reinstate the fees.

With the Legislature convening the second week in January, physicians who care for children must rely on the AMS and its legislative efforts to be in the forefront on issues pertaining to the health care of children and their access to that care. It takes this larger organization of all physicians to ensure that we keep the excellent package for children's health care that we now enjoy. ■

## ARCHITECTURE

FOR YOUR MEDICAL NEEDS

1 800 764 ASTI

**William Henry Asti, AIA**

architects, economists, development consultants

Buy — Sell  
Lease — Rent



The Med-Plus Group is a B2B website that helps medical facilities find the best prices available on New, Used, and Refurbished

medical equipment. With over 500 dealers, suppliers and manufacturers to select from, we have the solutions to meet your needs. In addition, we offer our customers flexible lease options to finance their purchase. Visit us on-line today or call Mike South or Rick Wooldridge for more information.



**MedPlusQuotes**

Healthcare Resources

(800) 643-0944 Fax (501) 224-0930  
www.medplusquotes.com  
email: rwooldridge@medplusquotes.com



# Arkansas Medical Society Insurance Programs....



## AMS BENEFITS, INC.

A wholly owned subsidiary of the  
Arkansas Medical Society

P.O. Box 55088

Little Rock, Arkansas 72215-5088

(501)224-8967

WATS 1-800-542-1058

FAX (501) 224-6489

"Available products include group  
health, office package, professional  
liability, home, auto, and more."

*tailor-made for physicians*

Insurance products are a fact of life. You can buy them almost anywhere. Fortunately there's one agency that only represents physicians...Arkansas physicians. AMS Benefits, with products to meet both your professional and personal needs.

Call us at 1-800-542-1058 or 501-224-8967



Original manuscripts are accepted for consideration on the condition that they are contributed solely to this journal. Material appearing in *The Journal of the Arkansas Medical Society* is protected by copyright. Manuscripts may not be reproduced without the written permission of both author and *The Journal of the Arkansas Medical Society*.

*The Journal of the Arkansas Medical Society* reserves the right to edit any material submitted. The publishers accept no responsibility for opinions expressed by the contributors.

All manuscripts should be submitted to Judy Hicks, Arkansas Medical Society, P.O. Box 55088, Little Rock, Arkansas 72215-5088. A transmittal letter should accompany the article and should identify one author as the correspondent and include his/her address and telephone number.

#### MANUSCRIPT STYLE

Author information should include titles, degrees, and any hospital or university appointments of the author(s). All scientific manuscripts must include an abstract of not more than 100 words. The abstract is a factual summary of the work and precedes the article. Manuscripts should be typewritten, double-spaced, and have generous margins. Subheads are strongly encouraged. The original, one copy and the manuscript on a 3-1/4" diskette should be submitted. Pages should be numbered. Manuscripts and diskettes are not returned; however, original photographs or drawings will be returned upon request after publication. Manuscripts should be no longer than eight typewritten pages. Word count should not exceed 1,700. Exceptions will be made only under most unusual circumstances.

#### REFERENCES

References should be limited to ten; if more than ten are listed, the author(s) may designate the ten most significant to be printed and readers will be referred to the author(s) for the complete list. References must contain, in the order given: name of author(s), title of article, name of periodicals with volume, page, month and year. References should be numbered consecutively in the order in which they appear in the text. Authors are responsible for reference accuracy.

#### ILLUSTRATIONS

Illustrations should be professionally drawn and/or photographed. Glossy black and white photos are preferred. They should not be mounted and should have the name of the author(s) and figure number penciled lightly on the back. An arrow should indicate the top of the illustration. In photographs in which there is any possibility of personal identification, an acceptable legal release must accompany the material. Up to four illustrations will be accepted at no charge to the author(s). If more than four are necessary, it is understood that the author(s) will be responsible for the reproduction costs.

#### REPRINTS

Reprints may be obtained from *The Journal* office and should be ordered prior to publication. Reprints will be mailed approximately three weeks from publication date. For a reprint price list, contact Judy Hicks at *The Journal* office. Orders cannot be accepted for less than 100 copies.



## Legislative Advocacy – Everyday, All Day

By DAVID WROTEN

**W**hile the Legislature is still in town, I thought you might like to know what a typical day is like during the legislative session.

Two members of our staff — Lynn Zeno, director of governmental affairs, and Laura Harrison — are at the Capitol daily. However, the entire AMS staff is involved one way or another to ensure that our legislative efforts are successful.

Each day actually begins the night before, when the many bills filed that day are reviewed. Bills that affect medicine are analyzed to determine the extent and nature of their impact. Mornings begin at the AMS office, where appointments are scheduled, bills on that day's committee agendas are identified, and strategies for achieving our legislative goals are discussed. Calls are made to seek advice and comment from AMS members and leaders.

By 9 a.m., the action moves to the state Capitol, where we meet with our volunteer physicians for the day. Each session, nearly 120 physicians will participate in the AMS Doctor of the Day program, providing volunteer medical care to legislators and Capitol employees. The AMS even maintains a temporary medical office on the third floor, known as the Shuffield Infirmary, after the late Dr. Elvin Shuffield.

House and Senate committees, where most legislative battles are won or lost, begin work at 10 a.m. AMS staff members attend these meetings daily, observing, providing testimony and often scheduling physicians or patients to testify. We frequently provide assistance to committee members by developing background papers and questions related to special issues.

Access to legislators is a precious commodity. Because House members don't have private offices for meeting constituents or lobbyists, most lobbying has to take place over meals, in the hallways of the Capitol and at social functions. For example, we usually take the Doctors of the Day and their legislators to lunch, offering an excellent opportunity to build relationships and bolster visibility.

A variety of activities takes place during the afternoons while the House and Senate are in formal session. Legislators are called out of the chamber to garner support for AMS positions. Meetings are held with the Bureau of Legislative Affairs to draft bills and amendments, with representatives of opposing interests to attempt negotiation or compromise, and with lobbyists for other health care groups to work as a team for or against certain bills. Once a week, the AMS hosts a meeting of these other health care groups known as the Health Care Providers Forum to discuss legislative issues and to develop strategies.

While most people are heading home, the evening work is just beginning. The AMS and six other groups sponsor a hospitality suite, known as the "choo-choo room," for legislators each evening between 5-7 p.m. The choo-choo room, always in the hotel where most legislators stay for the session, provides a non-confrontational atmosphere where legislators can freely discuss issues, with no pressure from lobbyists or constituents. Strong relationships and lifelong friendships, keys to legislative success, are frequent results of evenings in the choo-choo room.

The AMS often takes groups of legislators to dinner to further build these relationships. It could be a select committee such as Public Health, or groups such as the women's caucus or the minority caucus. While these dinners are primarily social in nature, issues are discussed, and we promote our positions on key issues and bills.

This is just the beginning of what the AMS does for you each and every day during the legislative session. The day ends as it began, with our group going over the bills introduced that day and preparing for the next day's work. ■



# To Merge or Not to Merge?

Few  
Physicians  
are Going  
it Alone  
These  
Days

**T**here's no doubt about it. The practice of medicine has changed dramatically in the past 50 years. For physicians to keep up with the constantly changing environment, one of the most recent trends in medicine has been the banding together of physicians from solo or small practices into larger physician groups. And in this day of managed care, it's easy to see why physicians don't want to be left out in the cold.

But what's not so clear is whether this recent merger storm will stick around. And the opinions regarding these large mergers aren't so easy to forecast, either.

While some doctors still denounce the excessive paperwork and the business atmosphere of large group practices, the majority of them are singing the praises of easier times when they no longer have to fly solo. Many doctors in group practices say banding together gives them leverage in an increasingly competitive environment, offers security and stability, and increases their bargaining position with health maintenance organizations.

Over the past 10-15 years, solo practices have dwindled, largely because of the onset of managed care and capitated fees.

*Bill Greene, CEO of Ortho-Arkansas, believes there are many benefits of merging physician practices.*

Bill Greene, chief executive officer of Ortho-Arkansas, believes mergers of physician practices help ease the pain of these changes in health care.

"The doctors have

the ability to negotiate contracts better and respond to managed care better," he said. "Being in a large practice also allows better access to ancillary services. For instance, in our practice we have several services, such as ambulatory surgery, physical therapy, MRI and the cardiology clinic."

Greene said large practices give doctors "economies of function" — access to more capital to buy equipment and hire better-trained staff. An easier lifestyle is another big benefit of joining a large practice, Greene said. Arranging time off and call rotations are not nearly the hassle they were when these physicians were solo. And the complexity of the business side of a private practice is often lessened in a large practice.

The Little Rock branch of OrthoArkansas — the result of the consolidation of the Arkansas Bone and Joint Clinic, the Little Rock Orthopedic Clinic, the TCS Orthopedic Clinic and Orthopedic Associates — represents just one of many mergers in the Little Rock area and across the state, Greene said.

"There have been a number of mergers in our market in the last two years," he said. "The surgery group at Baptist Hospital, most of the heart groups in town, the urology group — those are just a few merged groups in the area. Most major specialties have had at least one or more merger."

## Is There a Risk?

In most of these large group practices, the doctors are partners financially, or stockholders in the clinic and the clinic's assets, Greene said. The risk to doctors is minimal because the large group has an "ongoing life," he said.

"That's one reason why many people don't go into private practice," he said. "In a solo practice, there's one owner and a business, and when that owner gets ready to leave, there's not really anyone to sell it to, for the most part. That was not the case when you had a lot of people wanting to practice solo. Someone would come along and want to buy the older physician's practice, but that just doesn't happen anymore."

Graduating from medical school and hanging your shingle out for business is rare nowadays. Most surveys show that new doctors are joining existing practices where the risks aren't as high, Greene said.

"I think most of the remaining solo doctors have developed a niche where they can do exactly the kind of practice they want and can generate enough volume doing that practice," Greene said. "They

Photo: Mark Wilson

have a reputation for that niche, so they don't have to participate on a broader scale in a group."

### Flying Solo

Developing a niche practice is what Dr. Joseph Beck, a Little Rock medical oncologist, has done. Dr. Beck, whose niche is treating HIV patients, went from a solo practice to a group practice and is now back on his own — and, he said, much happier.

"I was solo from 1989 to 1995, and I was happy and taking good care of my patients. But at that time, just like everyone else in the country, I started listening to the low rumble of the train coming in that was this group-practice deal," he said.

There was a mutual respect among several oncologists in town who decided to merge and form the Little Rock Cancer Clinic.

Looking back, Dr. Beck said he joined the group practice partly out of fear: "I looked around and saw that everyone was doing it, and I thought to myself, what have I missed here? If everyone else is doing it, then it must be the right thing," he said.

Dr. Beck said he and the other doctors who joined thought that merging would give them economies of scale and that they would be able to cover more hospitals efficiently.

"We were able to get by with fewer employees for a while, and we had our economies of scale, but what came clear to me over time was that I didn't feel like I could take care of the patients as well.

"Instead of me being the boss, there were four bosses, and everybody had a different way of doing things. Nobody was wrong, but it was just different. It was sort of like a marriage."

In October 2000, Dr. Beck left the Little Rock Cancer Clinic and returned to private practice.

"Financially," he said, "it's a little bit of a fright the first several months, but for me, it has worked out and I'm happier. And the most important thing is I think I'm taking better care of the patients."

### Better Patient Care

In his group practice, Dr. Beck said, patients had a harder time accessing their doctors. The nurses were handling more calls than the physicians, which bothered Dr. Beck.

"The patients don't want to call and hear, 'Punch five and you'll hear a nurse and maybe at the end of the day a doctor will call back,' or, 'You can't talk to the doctor and the next available appointment time is in four weeks because the waiting room's so packed,'" he said.

"And that's part of what's wrong with health care today. People think the doctors don't care. They know that the profit motive is No. 1, the convenience factor is No. 2, and then No. 3 is maybe the doctors can get around to treating the sick people."

OrthoArkansas' Greene believes the large practices do provide patients better care for the sole reason that they can offer more in terms of service.

"In our case, in terms of facilities, we can offer better patient care in terms of the scope of service, and we also have the

ability to offer a broader range of appointment times and a variety of services that we didn't used to offer."

For Dr. Beck, being able to have a one-on-one relationship with his patients is extremely important.

"Being in a private practice allows me to keep my thumb on everything," he said. "I hear what goes on in the waiting room, and if I hear them telling a patient that I can't see him for three weeks but it was someone I told to call, then I can intercept that. I'd like to think that I've cut out a lot of this electronic delay. There's not this hierarchy."

### Is There an End in Sight?

Most health care experts agree that solo practices are quickly becoming a thing of the past. The traditional mom-and-pop way of taking care of patients has given way to a much larger and structured system.

But Greene of OrthoArkansas believes much of the merger madness is over.

---

**"Instead of me being the boss, there were four bosses, and everybody had a different way of doing things. Nobody was wrong, but it was just different. It was sort of like a marriage." — Joseph Beck, MD**

---

"I don't see as much perceived managed care pressure to drive mergers now, as far as our market here is concerned. Most of the logical combinations of doctors have already occurred, and so there are not as many opportunities for more mergers," he said.

He said he doesn't foresee a big influence in this market to drive multispecialty mergers. "That's more complex, politically," he said. "So I just don't see the forces right now to do that."

As for solo practices, Dr. Beck agreed that they are slowly diminishing.

"I'd like to be able to say that the future looks bright and that people are going to be able to have solo practices, but I don't think I can. Medicine is going to become more of a commodity. People are going to continue to want it quicker and cheaper. Ultimately, they'll get what they need, but it may not be what they want," he said.

Michael Helm, chief executive officer of Sparks Regional Medical Center, said the forecast for independent practices in Fort Smith looks the same as Little Rock.

"My experience in Fort Smith is that the independent practice of medicine is declining and the larger group tends to dominate," he said. "And what I read is that the merging trend tends to be leveling off. There was a significant amount of activity in the '90s, so in our community, there's not much left to consolidate."

Helm said Fort Smith's physicians had consolidated to retain a voice in their medical practices.

"Small, independent practices have very little influence, whereas larger practices have much more influence. That has enticed physicians," he said.



Helm said Fort Smith differs from Little Rock in that most of the mergers have been developed from the hospitals. He said there had been very few independent management companies and proprietors behind the big mergers.

For instance, he said, Cooper Clinic and Crawford Memorial Hospital in Van Buren — much like Holt Krock Clinic and Sparks in Fort Smith — have both acquired and developed several group practices.

Dr. Beck has his own theory why the merging began.

"Greed on the part of some of the insurance companies. They're real happy to open the envelopes that the premiums come in, but they're not so happy about paying for the care," he said.

He said the merging began when medicine became a business instead of a vocation. "In the early '90s, it became common that [the insurance companies] wouldn't take a doctor's word that a treatment was necessary, and so doctors had to call and preauthorize treatments, and it just sort of snowballed from there," he said.

### Larger Than Life

Although there are benefits to a large practice, Dr. Beck said one of the biggest drawbacks is how long it takes to make decisions, often on simple things.

"In a large group practice, you can't go to someone and say, 'I'm tired of using this sort of paperclip. I want to use this kind,'" he said. "There has to be a report and a study done and a purchasing order. And then they have to be approved by the CFO, and all the doctors have to get together and approve it. Take that and magnify it for every decision, whether it's a brand of gloves, brand of chemotherapy. ... For me, it was easier to get rid of all that extraneous stuff and go back to a much simpler model."

Greene agreed the politics in a large practice could be challenging.

"The relationship issues are more complex, and the politics within the group are certainly more challenging," he said. "Groups have to make good, collective decisions to be successful, and that's not always easy. But I think the positives of merging far outweigh the negatives."

Although a large practice didn't suit Dr. Beck, he acknowledged that there are benefits to that structure. Economies of

scale, group collaboration, the convenience of being able to take time off and the ease of contracting with hospitals and insurers are all perks.

"No doctor wants to become a businessman, but I've had to again. I've had to look at my costs carefully. But there's really nobody who's going to take care of your business as good as you are," he said.

He said that although it is a benefit that large groups have someone to take care of their finances, it also can be deceptive.

"The physicians don't have much training in economy and finances, so they listen to the CFOs and bean counters. But the stuff the CFOs tell them is like a quote from my favorite author, Flannery O'Connor: 'reasonable sounding but wrong.' And I think that's what happens a lot of times," he said.

### A Thriving Relationship

The purchase of Fort Smith's Holt Krock Clinic by the city's largest hospital system is a good example of how large groups can benefit both physicians and the hospitals.

Sparks Regional acquired the clinic in 1999. The sale of the clinic was to settle the war waged between its physicians and the clinic's owner, PhyCor Inc., a physician practice management company in Nashville, Tenn. After Sparks acquired Holt Krock, the Sparks Medical Foundation was created.

"In our case, we were put in a position of having to acquire the clinic because of the instability, and the main goal we achieved was the stability of our medical staff," Helm said. "There was no significant market shift through the acquisition."

Helm said that as a result of the creation of the foundation, it is much easier to contract with payors by having a single signature authority for both the physicians and the hospital. "And probably the payors find it much easier as well. All of our doctors participate in all the contracts," he said.

Helm said that since the acquisition, the foundation had recruited 45 new doctors and is operating 54 practices in Arkansas and Oklahoma at 38 locations. There are 120 physicians total, he said.

"We've had very good relationships with our doctors," Helm said. "The main benefits this acquisition has brought is stability, efficiency, the creation of a very seamless system of care for our patients, the potential for our physicians to practice more effectively and the ability to deal with third-party entities more effectively."

Helm said all the doctors are employed by the hospital and must abide by the policies set forth by the foundation. He said the clinics were able to select their own practice name, however.

"Some chose to include Sparks in their name, but they all work under the umbrella of the Sparks foundation," he said. "We do all their billing and marketing."

### The Future of Medicine

Helm believes the future of group practices depends on the circumstances in the community.

"Joining the large groups will work for some but not others. Every institution and every provider has to determine what the best course of action is for their community. There's no simple answer."

He offered some advice to doctors considering moving into a group practice. "That individual has to find value in a group or they won't be happy," he said. "A physician who's considering moving into a group or being acquired by a hospital should consider the pros and cons before making the decision."

As for Dr. Beck, he chooses the mom-and-pop way of providing health care.

"I don't want to be the Wal-Mart — I want to be the corner drugstore," he said. "I can do almost as well, and maybe my profit margins won't be the same as Wal-Mart's, but sometimes people don't like going to Wal-Mart. Sometimes they don't like waiting in a line of 30 people to buy some laundry detergent. And maybe they wouldn't mind going to a smaller place and paying a few more pennies to get what they want."

"I can't criticize anyone for going into one of those mergers. I did myself. Doctors were just driven by fear when it all began. It was like a defense mechanism. There's that old saying that says, 'Those who don't embrace their fate are doomed to be dragged by it,' and I think a lot of doctors looked at it that way." ■

# Meet Our Members

## Heather Melissa Diemer

By SHELBY BREWER

Getting a “C” in college chemistry didn’t discourage Heather Diemer from following her dreams of entering medical school. In fact, it challenged her to try even harder.

“It was during my freshman year of college, and I was told by my adviser that if you can’t make an ‘A’ or ‘B’ in freshman chemistry, then there’s no way you can go to med school,” Diemer said. “So I spent the entire Christmas break frustrated and upset.

“So the second semester, I took it and made one of the top five grades out of a class of about 300. I was so mad that someone told me I couldn’t do it, so I went to the extreme and even ended up tutoring in chemistry for the next four years.”

Such challenges are what keep this 26-year-old med student going.

A junior at the University of Arkansas for Medical Sciences, Diemer is no stranger to the Little Rock area. She has lived in Little Rock all her life — she has even lived in the same house.

Diemer got her bachelor of science in biology from the University of Arkansas in Fayetteville. After graduating in 1996, she stayed another year to work as a residence hall director, which enabled her to take master’s level classes in counseling.

But it turns out the job wasn’t all she thought it would be. “After I started it, I ended up hating it. It was just a lot of red tape, and it really bogged me down, so by then I was ready to go to medical school.”

So Diemer applied for and accepted a research position at UAMS. She returned home to Little Rock and spent a year conducting research and waiting tables at Bennigan’s while applying for medical school.

Diemer did her research in the department of family and community medicine. She worked with a psychiatrist, helping him develop ways to detect mental illness in the family practice setting, and she also did a work-flow study of the clinic, which

she said allowed her to follow doctors around all day while getting paid.

“I was like a fly on the wall, observing everything, and they treated me just like a med student. I really learned a lot,” she said.

Finally, the time came for Diemer to interview for medical school. “I walked out of there knowing I was going to medical school,” she said. “In fact, they told me I was the best interview candidate they had seen all day.”

Diemer received her acceptance letter on Valentine’s Day, and she decided to give herself a little treat. “The very next day, I bought a plane ticket to Europe. I promised myself that if I got accepted, I would go to Europe for three weeks.”

Diemer made the trip alone. She wandered around Paris and Germany and even got stuck in Spain. “I was there when all the trains went on strike. I got really stressed out. No one spoke English, and my parents didn’t know I was by myself. But I just wanted to see if I could do it. It was awesome, but I’d never take a trip alone like that again.”

Using the money she had saved from her waitressing job, Diemer thinks she did pretty well with her money. “I only spent about \$1,600 for three weeks. I stayed in youth hostels and slept on the train a lot.”

Diemer, the middle among three sisters, has plans of becoming a family doctor. But the buck doesn’t stop there. She also wants to specialize in adolescent medicine and, after her residency, get a master’s in public health and work in a fellowship in adolescent medicine.

It was a summer camp that initially sparked Diemer’s interest in working with teenagers. “When I was a kid, I was a camp counselor at the Joseph Pfeifer Kiwanis Camp in Little Rock that serves youth at risk,” she said. Diemer found out about the camp from her stepfather, who went there when it was the Boys Club camp. Diemer started attending the free camp at age 8.

“I was a product of

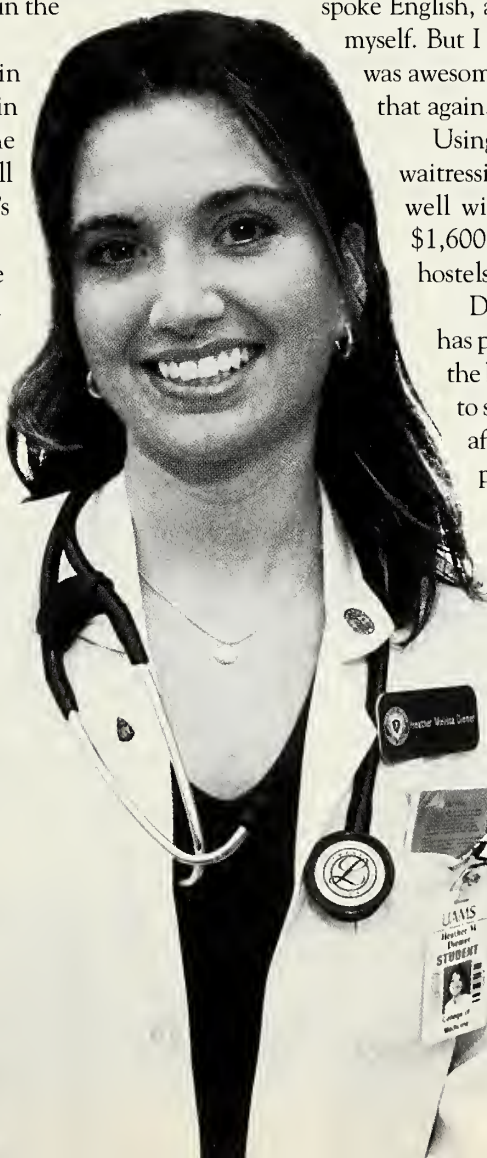


Photo: Corbet Deary



divorce and my family was poor, so I was coined a youth at risk," she said. When she was 12, she became a counselor in training, and, at age 15, she became the youngest counselor the camp had ever had before.

At the camp, Diemer met a man whom she described as her life mentor. His name is Sanford Tollette, and he is the camp director.

"He would take me under his wing, and he has this ability to look at someone and see into them. And that was always one of my goals — to look at someone and see their motivations and soul. That's what I want to do with teen-agers. I want to give them a chance and see them as people," she said.

Another inspiration in Diemer's life was her sixth-grade teacher, Becky Coburn, who taught at Fuller Elementary. "She was the first person who made me want to pursue medicine," Diemer said.

"She ended up dying of cancer. It was my sixth-grade year when she got it," Diemer said. "She taught me so much. She never underestimated our abilities, and she was the first person I ever experienced being sick. And I was so frustrated because they couldn't save her.

"I continued to visit her every year until I was a senior. She had been in remission, but it had come back full force when I graduated. Since I was second in my class at Mills High School, I got to give a speech, and I talked about her in my speech and dedicated it to her," Diemer said.

"She died that year, but for my graduation present, she gave me a bag of really smooth stones, and she called them her 'wish stones.' She told me that no matter what happened, all I'd have to do was rub the stones and she would always be there to watch over me," Diemer said.

While in high school and college, Diemer was involved in both her school and community. Some of her activities included Students Against Drunk Driving, student government, food drives, the American Red Cross and Meals on Wheels, and her involvement continues today.

Diemer is an alternate delegate for the Arkansas Medical Society's student section. As an alternate, she must be available to attend the national

conferences of the American Medical Association and vote on behalf of the student section if the delegate cannot attend. But Diemer has taken the position to a whole new level.

Not only has she rewritten the bylaws of the student section, but she has also helped the president with organizing conferences and helped bring a national grassroots program called the Legislation Action Committee to the Little Rock chapter.

But Diemer said her biggest role has been to encourage other students to join the student section of the Arkansas Medical Society.

"I try to educate more students about the necessity of being involved at this level. Right now is the time to start. We need to be involved simply for the fact that everything that goes on will affect us 20 years down the road. All the laws being passed, all the issues with HMO and insurance companies will dictate how we will practice medicine," she said.

Diemer also said the society has helped her build connections with doctors across the state and nation, as well as with other med students. Diemer is also involved in the Arkansas Academy of Family Physicians as well as many other organizations.

Besides being a doctor, Diemer also wants to be involved in politics. "I want to be a practicing physician, but I also want my time to be divided by working as a lobbyist in the political arena. I want to be an advocate for public health issues," she said.

"I want to be the doctor that the senator goes up to and asks, 'Is this going to be a good bill or will it affect doctors negatively?'"

Diemer said she would like to do her residency on the East Coast, maybe in Virginia, North Carolina or South Carolina. "I've looked at Boston, too, but I don't want to be that cold," she said, laughing.

Diemer also said she hopes to marry and have children, although not getting married is also one of her fears. "I'm scared that I'll have this great career and never settle down and get married," she said.

"When I first came to medical school, I had three rules: never date someone in my class, never be a pediatrician and

never marry a doctor. Well, I started off dating someone in my class, and even though I want to be a family doctor, working with teen-agers is a big part of pediatrics. And now I'm seeing a medical student from New York that I met at an American Medical Association meeting."

What she's looking forward to the most about being a doctor is making an impact.

"I want to help [people] learn that maybe what's medically wrong with them is related to the fact that their life is so stressful. I want to teach them that they need to treat all parts of their life. I believe the body is guided by the mind and vice-versa," she said.

Diemer said she doesn't want to work in a city smaller than Little Rock, but she doesn't want to live in a big city, either. "Part of my passion is the outdoors, and living in a city full of concrete would just drive me crazy," she said.

Probably the hardest part about being in medical school is that everything is always new, she said. "You spend the first few days in a rotation, learning what to do, and when you finally learn it, it's time for another rotation. It's very exhausting."

Diemer said being in medical school has also affected her sleep. "I used to joke that I could sleep on the side of the highway, but when I started medical school, my stress got so high that I could not sleep. My mind just never shuts down, and sometimes I only get two hours of sleep," she said.

Fortunately, she has several methods of dealing with stress. "I relax by working out," she said. "I've been doing step aerobics for a while, and I try to work out at least four nights a week. I also love to mountain-bike and read suspense and science-fiction novels."

Diemer said she feels lucky to be a woman medical student in this generation. "The females before us have had to fight so hard. They've literally paved the way for us. We don't have as many injustices now," she said.

She said the most critical issue today regarding the medical field is deciding who is going to practice medicine. "Is it going to be the physician who has trained for years and years and has the patients' best interest at heart, or is it going to be the HMO and insurance providers?" ■

# Managing Diabetes Mellitus

ROBERT H. HOPKINS, MD

**T**he diagnosis and management of patients with diabetes mellitus are common in most adult and many pediatric primary-care settings. Appropriate care can prevent or delay morbidity due to neuropathy, vision loss, renal failure, cardiovascular disease and amputation. In addition to the physical costs of this disease to patients, it puts an immense financial burden on individuals and society. Many health care organizations, both public and private, have targeted diabetes management as a marker for quality health care.

The goal of this review is to provide an update regarding the most recent guidelines from the American Diabetes Association (ADA) on diabetes care and an overview of identified quality indicators for the management of diabetes mellitus.

## Diagnosis

Assignment of a particular type of diabetes is probably less important than making the diagnosis and understanding the pathophysiology of the disease in a given individual. The ADA expert committee has recommended using the terms Type 1 and Type 2 to indicate the most common forms of the disease. Type 1 is the disease most commonly originating in childhood and is characterized by absolute insulin deficiency. It may be idiopathic or autoimmune in origin. Type 2 is the most common form of diabetes. Patients manifest a combination of inadequate insulin secretion and insulin resistance. The other specific types of diabetes and associations with other conditions constitute a small minority of diabetic patients.

Impaired glucose tolerance and impaired fasting glucose are categories that are clinically useful only as risk factors for future diabetes mellitus and cardiovascular disease. These

conditions may persist in a given individual for an indefinite period without meeting the criteria for diabetes.

Fasting plasma glucose and random plasma glucose measured on two separate days are recommended as the principal screening methods for diabetes. Repeated testing is not necessary to diagnose diabetes mellitus in patients with unequivocal hyperglycemia and metabolic decompensation. The 75 g oral glucose tolerance test may be used for diagnosis of diabetes mellitus; but its inconvenience for the patient and physician, limited reproducibility and increased cost reduce its utility in screening the general population. Some authorities recommend using the hemoglobin A1c for diagnosis; this approach is limited by cost and standardization of the assay across different laboratories. The use of hemoglobin A1c for monitoring of glycemic control in most patients is uncontested.

A fasting plasma glucose  $\geq 126$  mg/dl or a random plasma glucose  $\geq 200$  mg/dl in a patient with symptoms of diabetes meets the criteria for a provisional diagnosis of diabetes and should be confirmed on a separate day. Fasting plasma glucose  $\geq 110$  mg/dl and  $< 126$  mg/dl constitutes a preliminary diagnosis of impaired glucose tolerance. Screening of patients beginning at 45 years of age, or younger in the presence of personal or family risk factors for diabetes, is recommended to reduce the large population with undiagnosed Type 2 diabetes.

Large prospective trials have demonstrated that strict glycemic control potentiates reductions in the absolute and relative risk of microvascular com-

## Core Concepts

**Hemoglobin A1c** should be documented in the medical record at least semiannually, along with an assessment of glycemic goals.

**Dilated retinal examination** should be performed and noted in the medical record at least every 12 months.

**Fasting lipid profile** should be measured annually, or more frequently if indicated; treatment should be as prescribed in the National Cholesterol Education Project.

**Urinalysis** should be noted annually. This should be followed up as appropriate: if protein on urine dipstick, albumin excretion should be quantified (protein/creatinine ratio or timed urinary protein excretion), or if dipstick for protein is negative, with urinary microalbumin/creatinine ratio.

**Foot examination** with specific notation of sensation, skin integrity and vascular status should be performed and itemized at least annually. Patient education about foot care and appropriate footwear/protection should also be evident.

**Pneumococcal vaccine** should be given to all adults with diabetes  $\geq 65$  years of age.

**Influenza vaccination** annually, administered before influenza season.

**Dietary education** should be documented in the medical record.

**Smoking status** should be documented and, as appropriate, counseling or referral given for smoking cessation.

**Exercise program** should be given and documented in clinical records.

## Management

Editorial Panel: William E. Golden, MD; Deborah L. Marple, RN, BS, CPHQ; Donna S. West, PhD; Nancy P. Archer, RN, BS, CPHQ.

Arkansas Foundation for Medical Care (AFMC) is the Peer Review and Quality Improvement Organization for Medicare and Medicaid in Arkansas. AFMC works collaboratively with providers, community groups and other stakeholders to promote the quality of care in Arkansas through evaluation and education. For more information about AFMC quality improvement projects, call 800-272-5528, ext. 204.





*Introducing the*

## DIAMOND STAR

**Fast: 147 Knots / 169 MPH**  
**Affordable: Ownership from 25% to 100%**  
**And Fun!!!**



Call Cheri McKelvey  
**501-975-9321**



lications in both Type 1 and Type 2 diabetes. Intensive diabetes control, unfortunately, also carries an increased risk of more frequent and severe hypoglycemic events. The degree of glycemic control desired must be individualized based on a risk/benefit analysis in any given individual. Patients and their physicians must collaborate in establishing treatment goals for short- and long-term glycemic control. Self-monitoring should be instituted in most patients with diabetes. Blood glucose goals should be 80-120 mg/dl before meals and 100-140 mg/dl before bedtime. The optimal frequency for home blood glucose monitoring in Type 2 diabetes must be individualized.

The frequency and intensity of physician visits will necessarily vary with the type of diabetes, glycemic goals and the degree of achievement of those goals, and the need for treatment modification due to the complications of diabetes and other medical illnesses.

Hemoglobin A1c should be measured regularly to assess achievement of metabolic goals. The absolute frequency of monitoring will depend on the degree of an individual patient's glycemic control; most authorities suggest at least semiannual measurement.

Hemoglobin A1c is not a valid measure of glycemia in patients with sickle-cell trait or other hemoglobinopathies; measurement of other glycosylated plasma products such as fructosamine may be used to assess control in patients with these comorbidities.

Dilated retinal screening and a thorough foot examination are recommended annually in all adult diabetics. Urine should be screened for protein excretion yearly.

Adults with diabetes should also have fasting lipid profiles measured each year, and treatment should be undertaken with a goal of LDL reduction to  $\leq 100$  mg/dl.

Aggressive blood-pressure control in patients with Type 2 diabetes has been demonstrated to reduce diabetes-related death and vascular disease. Blood-pressure control to 130/85 or less is recommended in diabetics. ACE



Healthcare Professional Liability  
 Business/Workers' Compensation/Life & Retirement  
 Planning

Managing the business side of healthcare is time consuming, but FARMERS helps get you back where you belong—delivering quality medical care.

For almost 50 years, Farmers Professional Liability has specialized in providing coverage and risk management solutions to the changing liability risks associated with the delivery of healthcare.

Our Physician Program offers solutions to, and exacting coverage for, today's broad spectrum risk exposures.

We make it simple—with one call we can handle all your insurance needs!



Mark Perry  
 112 Municipal Drive  
 Jacksonville, AR  
 72076  
 (501)982-4561  
 1-800-467-2436  
 mperry@alltel.net

Joanna Owens  
 712 A Bradley Dr  
 Mtn. Home, AR 72653  
 (870) 424-2120  
 1-888-424-2120  
 baxterinsurance@yahoo.com





inhibitors should be used in antihypertensive regimens and in patients with albuminuria unless contraindicated. Daily aspirin and efforts to correct other cardiovascular risk factors are indicated in patients with diabetes and evidence of vascular or cardiovascular disease.

All patients with diabetes should receive education on nutrition and lifestyle modifications such as smoking cessation and exercise. Patients with severe or recurrent hypoglycemia or hyperglycemia that is difficult to control may benefit from referral to a multidisciplinary diabetes-care management program.

### Arkansas Performance

Recent national evaluation of Medicare outpatient claims data indicates that compliance with these recommended clinical strategies is below national average. More than 40% of diabetics with Part B Medicare insurance in Arkansas did not receive any monitoring with the hemoglobin A1c test. This put Arkansas 49th in the country, as did the low use of lipid screening (43%) in this population. Slightly more than two-thirds of Arkansas diabetic patients with Part B received a dilated eye examination within two years, and that rate was 35th best in the country. Since these data were collected, the Arkansas Foundation for Medical Care has been engaged in public and professional educational campaigns to heighten awareness of these guidelines and to change clinical behavior and improve the state's profile in the care of diabetes.

### Conclusions

Many of the advances in diabetes management over the past decade are directed toward stricter glycemic control and surveillance for other metabolic complications such as hypertension, hyperlipidemia, vascular disease and nephropathy. Medicare audit data to date show suboptimal rates of key indicators of quality care such as annual hemoglobin A1c measurement, dilated retinal exam-

Doctors Complex with over 275,000 square feet of Class A Medical Office space is conveniently located in the heart of Little Rock's Medical Corridor and within a three mile radius of St. Vincent Infirmary, UAMS, Baptist Medical Center, Little Rock's VA Hospital, Arkansas Childrens' Hospital and adjacent to St. Vincent Doctors Hospital.

SUITES

AVAILABLE

FROM

496 SQUARE FEET

TO

2436 SQUARE FEET

**LRMA**

DOCTORS BUILDING - DOCTORS PLAZA

### LEASING INFORMATION:

Betty Garcia Little Rock Medical Associates

Phone: 501-664-1812

Fax: 501-664-9212

E-mail: [egarcia@lrma.com](mailto:egarcia@lrma.com)

## Medical Practice Consultants, Inc.

An Arkansas-Based Firm with Over 75 Years  
of Medical Practice Knowledge

- Custom-Designed Compliance Program
- Coding and Documentation Evaluations
- Practice Assessments With Reports

Call 1-870-236-1899

for information on affordable services  
designed to meet YOUR medical practice needs

**M P C**

Donald B. Smith

— CEO

Benjamin "Mac" Butler

— Consultant

Patty Pendergrast

— Consultant



## Continuing Medical Education Upcoming Events

### 1. MEDICAL MALPRACTICE IN THE 21<sup>ST</sup> CENTURY

Saturday, March 10, 2001  
Half Day CME Seminar  
Fayetteville, Arkansas

### 2. FISHIN' & FACTS- PRIMARY CARE HOT TOPICS

April 27-29, 2001  
Gaston's Trout Fishing Resort  
Lakeview, Arkansas

For more information, contact  
Regional's CME office at (501) 713-1823.

Sponsored by:



WASHINGTON  
REGIONAL

MEDICAL CENTER  
Fayetteville, Arkansas

## MEDICAL DIRECTOR

Little Rock, Arkansas

Are you interested in joining one of the most recognized and successful Managed Service Organizations in America? Practice Plus, an affiliate of Arkansas Baptist Health, is seeking a Medical Director to join our Senior Leadership Team to help coordinate clinical functions in over 20 clinics. The successful candidate will have proven leadership skills, clinical teaching and medical administration in a multiple clinic environment. The selected candidate will be responsible for Strategic Leadership in regulatory compliance, physician/staff education and clinical enhancements. Potential opportunities also exist for some part-time patient care in a clinic setting.

If you are interested in joining a strong principle-centered leadership team please submit your confidential inquiries to:

### PRACTICE PLUS

904 Autumn Road • Suite 400—Attn: RBS  
Little Rock, AR 72211 or Fax to 501-202-4012

inations and lipid profiles. Nationwide, and in Arkansas, increased compliance with these indicators in day-to-day practice should help reduce morbidity and mortality for patients with diabetes mellitus. ■

### Author Affiliation

Dr. Hopkins serves as associate program director for the Internal Medicine and Pediatrics Residency Programs at the University of Arkansas for Medical Sciences. Additionally, he is an assistant professor in the Department of Internal Medicine and an instructor in the Department of Pediatrics at UAMS. He holds board certification in both internal medicine and pediatrics and actively practices in the Little Rock metro area. As a pediatrician, he has extensive experience in the promotion, education and implementation of well child care and is an excellent resource for pediatric standards of practice.

### References

American Diabetes Association  
Position Statement: "Standards of Medical Care for Patients with Diabetes Mellitus." *Diabetes Care*. 22(1999):S32-S41.

DCCT Research Group. "The Effect of Intensive Insulin Treatment of Diabetes on the Development and Progression of Long-term Complications in Insulin-dependent Diabetes Mellitus." *New England Journal of Medicine*. 329(30 September 1993):977-86.

DeFronzo, Ralph A. "Pharmacologic Therapy for Type 2 Diabetes Mellitus." *Annals of Internal Medicine*. 131(17 August 1999):281-303.

Haffner Steven M. Technical Review: "Management of Dyslipidemia in Adults with Diabetes." *Diabetes Care*. 21(January 1998):160-78.



# CASE OF THE MONTH

## Suspected Insulin Anaphylaxis and Literature Review

BLAKE G. SCHEER, MD — KARL V. SITZ, MD

### Abstract

Insulin allergy is a well-documented complication of insulin therapy. A 67-year-old man presented with symptoms suggestive of insulin anaphylaxis. In an attempt to allow him to continue insulin therapy, he underwent a desensitization protocol. During the protocol, he again experienced symptoms suggestive of anaphylaxis. An analysis of his case is presented in the context of current literature. All physicians treating patients with insulin should be aware of this serious complication.

### Case

A 67-year-old white man with a history of chronic pancreatitis, now with diabetes after a partial pancreatectomy in 1996, was initially treated with the oral agents glimepiride (Amaryl), metformin (Glucophage), troglitazone (Rezulin) and acarbose (Precose) without control of his blood sugars.

About six months before his visit to our clinic, he was started on insulin. His regimen at the time was Humulin Regular 5 units and NPH 10 units twice a day, which gave him good control of his blood sugars.

However, after three months on this regimen, he gave himself an injection in the right thigh and immediately became dizzy, dyspneic, diaphoretic, pruritic and was near syncopal. He said the symptoms lasted only a few minutes,

resolving before he could pick up a phone and call for help. He felt normal within 30 minutes.

He told his primary-care physician about this and was told to stop his insulin until he could be further evaluated for the cause of the episode. By history, his reaction seemed likely to be from anaphylaxis but could also be from hypoglycemia. He resumed taking 10 mg glyburide twice a day until his appointment.

He had no other medical problems and his past surgical problems also involved a cholecystectomy, a right inguinal hernia repair and a tonsillectomy. He had no other known drug allergies and was taking vitamin E, vitamin C and acetaminophen

in addition to insulin. His vital signs were normal, and the only pertinent findings on physical exam were a 2/6 systolic ejection murmur at the apex, and a split S2 with inspiration. His HbA1c was 9.36.

During his initial evaluation, the need for insulin therapy was discussed. It was felt, based on endocrinology consultant recommendations, that desensitization to 10 units of NPH insulin would be most appropriate.

Desensitization was chosen as the initial procedure, since many patients on insulin therapy have clinically insignificant skin test reactivity, and toleration of insulin therapy was the final clinical goal.

All of the risks and benefits, including

Table 1.

Time (AM)	Units NPH Insulin	Route	Vital Signs Before Injection	Vital Signs After Injection	Reaction
08:00	0.0001	Intradermal	P=94 BP=124/80 R=18	Unchanged	None
08:30	0.001	Intradermal	P=94 BP=124/78 R=20	Unchanged	None
09:00	0.01	Subcutaneous	P=94 BP=120/80 R=20	Unchanged	None
09:30	0.1	Subcutaneous	P=96 BP=115/70 R=18	P=weak/thready BP=70/- R=12	Odd feeling, head pruritus, brief loss of consciousness
10:00	1	Subcutaneous	Aborted		
10:30	5	Subcutaneous	Aborted		
11:00	10	Subcutaneous	Aborted		



the risk of anaphylaxis, were discussed with the patient, and he provided informed consent.

## Methodology

The patient began the desensitization according to the protocol shown in Table 1. A peripheral IV was started, and a resuscitation cart was placed in the room. Serial dilutions of Humulin NPH insulin were prepared using sterile saline. Insulin syringes were used to inject 0.1 ml of each dilution either intradermally or subcutaneously (as called for in the protocol).

Each injection was carefully aspirated to prevent intravenous injection. There were no problems or adverse reactions until after administration of 0.1 unit of insulin subcutaneously. Within 10 seconds of administration, the patient said he felt funny and also was itching on top of his head. He briefly lost consciousness and slumped over in his chair.

An ampule of D50 was immediately administered, and, before epinephrine could be injected, the patient regained consciousness, and his vital signs returned to normal within 10 minutes. There was no wheal or erythema at the site of injection. The procedure was aborted at this point, and the patient was observed for the next six hours before he was allowed to leave.

We discussed the need to further investigate this occurrence before restarting insulin of any kind. The endocrinology consulting team agreed and believed the patient might benefit from troglitazone again.

However, since the patient was moving from this area, and considering the risks involved if he was lost to follow-up, it was decided to use glyburide alone.

## Discussion

Insulin complications have been documented since the first available insulin was used in 1922. Although the most common complication has always been hypoglycemia, allergic reactions were among the first observed. The precise incidence is unknown, but 40-50% of patients receiving animal insulin preparations develop clinically insignificant positive skin test reactivity to the insulin selected for treatment. Insulin reactions have been shown to be

IgE mediated in repeated reports with immunologic laboratory testing, such as ELISA and RAST, as well as with provocative skin testing.<sup>1</sup>

Anti-insulin IgE has the ability to attach to the outside of mast cells and basophils and is otherwise not functioning until the antigen is encountered again. When insulin is reintroduced, the antigen binds and cross-links the IgE on mast cells. Immune response mediators are released, such as histamine, prostaglandins, leukotrienes, proteases (tryptase), cytokines and other chemotactic factors, which produce the clinical reaction.

These responses usually occur locally, such as erythema and pain at the injection site, but occasionally, systemic reactions can occur.

Since animal insulin preparations were the first used and first reported, it was previously thought that the sensitivity was caused by xenogenic (cross-species) recognition of animal insulin. However, insulin allergy has been documented, although less frequently, since the advent of human recombinant insulins.<sup>1</sup>

In one patient, it was documented that a systemic IgE-mediated response developed to her own endogenous insulin, having symptoms in response to taking sulfonyleureas.<sup>2</sup>

The best explanation for the decrease in sensitivity with the new insulins is probably found in the processes of preparing animal insulin for human use. The insulin proteins are slightly denatured, altering their tertiary structure, exposing allergenic epitopes of the insulin molecule. This would make them more accessible to the immune response of the recipient.

Allergic reactions to other proteins can mask themselves as insulin allergies. One of the most common is that of protamine, found in NPH (neutral protamine Hagedorn) insulin.<sup>3</sup> Zinc is another additive that has been documented.<sup>4</sup> Others include latex in insulin syringes and the glue in insulin pumps.<sup>5</sup> These are just some of the known peptide contaminants that have been documented to elicit an immune response.

Other local reactions, such as lipoatrophy and lipohypertrophy, also can occur.<sup>6</sup> Lipoatrophy is localized depression of the skin in the area insulin has been injected. This process could be immune-

related, since the incidence is less with human insulin preparations. Lipohypertrophy is local swelling in areas of repeated insulin injection. This problem is not only a cosmetic problem, but it can alter the ability of insulin to be absorbed in the affected areas. The swelling usually subsides modestly with a change in injection sites. This was a main reason for initiating a rotation of injection sites.

Patients can also develop edema as a result of better glycemic control from the sodium-retaining properties of insulin, but it is usually self-limiting with a newly diagnosed diabetic or with the initiation of insulin therapy. Occasionally, diuretics are used for a short time to relieve symptoms.

Did this patient have an anaphylactic reaction to insulin?

There are some caveats to consider. The first of these is the lack of an obvious cutaneous reaction, such as the classical wheal and flare response, during the episode. The very young and the elderly may have diminished skin reactivity because of poorly functioning cutaneous immunity.<sup>7</sup>

Other things that can decrease the skin response include recent medicines, such as antihistamines, poor potency of the allergen given, or injections given too deep to see the cutaneous response.<sup>8</sup>

This patient's age and underlying medical condition, along with the subcutaneous administration of the insulin, may have obscured a cutaneous response. Measurement of serum tryptase levels may sometimes confirm the release of mediators associated with anaphylaxis.

Although the patient recovered immediately after a rapid IV glucose infusion, it is unlikely that a total of 0.12 units of NPH insulin given during the procedure could cause hypoglycemia, especially since he had eaten breakfast on the morning of the procedure and his self-reported fasting blood sugar at home was 120 mg/dl. His apparent immediate response to the glucose was most likely coincidental, since anaphylactic reactions may be brief and self-limited. His reaction resolved rapidly before epinephrine, the drug of choice for anaphylaxis, could be injected. In hindsight, epinephrine should have been given instantaneously, with glucose administration as a second procedure.



Therefore, the patient likely had an anaphylactic reaction to a component of the insulin preparation. Skin testing to all of the possible antigens, particularly regular insulin, NPH insulin, protamine and latex may have helped clarify the inciting protein. In-vitro measurements of specific IgE, such as RAST testing, could also have been informative, particularly if skin testing failed to give a diagnosis.<sup>4</sup> These were unable to be done since, soon after the patient's clinic visit, he moved out of state. To our knowledge, no further evaluation has been attempted at this time.

With a strong suspicion of an IgE-mediated systemic reaction to insulin, the patient had several options. First, he could be treated more aggressively with oral medicines, as we did on discharge with this patient. If he continued to fail oral medications, other preparations of insulin could be attempted. Lispro insulin has been shown to be tolerated in patients with insulin allergy.<sup>9</sup> Sheep-derived insulin has also been used, but is very rare and not readily available.<sup>10</sup>

It may also be possible to admit the patient into the hospital under close monitoring and attempt desensitization again. It is very rare to find a patient resistant to desensitization, but it has been described. A last-resort possibility is the use of prednisone to diminish the immune response,<sup>2</sup> but this treatment is undesirable because of the many side-effects of long-term steroid use, particularly in patients with diabetes.

Since the patient has left our area, his diabetes management is uncertain. We discussed the need to consult an allergist to further evaluate this rare and possibly life-threatening reaction he demonstrated in our office.

## Conclusion

Insulin allergy is a known, well-documented adverse reaction to insulin therapy. Primary-care givers should be alert in recognizing this condition. Collaboration between allergy and endocrinology specialists should lead to a careful diagnostic and treatment plan. With the use of alternative forms of insulin therapy or desensitization, most patients with documented systemic insulin allergies are able to control their blood glucose. ■

Dr. Scheer is with the division of allergy and immunology at St. Louis University. Dr. Sitz is with the Little Rock Allergy and Asthma Clinic PA.

## References

1. Patterson, R, Roberts, M, Grammer, L. Insulin allergy: Re-evaluation after two decades. *Annals of Allergy*. 64: 459-62; May 1990.
2. Alvarez, T, Rosenwasser, L, Brodie, T. Systemic allergy to endogenous insulin during therapy with recombinant DNA (rDNA) insulin. *Annals of Allergy, Asthma, and Immunology*. 76(3): 253-6; Mar 1996.
3. Dykewicz, M, Kim, H, Orfan, N, Yoo, T, Lieberman, P. Immunologic analysis of anaphylaxis to protamine component in neutral protamine Hagedorn human insulin. *Journal of Allergy and Clinical Immunology*. 93(1):117-125; Jan 1994.
4. Bruni, B, Barolo, P, Gamba, S, Grassi, G, Blatta, A. Case of generalized allergy due to zinc and protamine in insulin preparation [letter]. *Diabetes Care*. 9: 552; 1986.
5. Towse, A, O'Brien, M, Twarog, F, Brimon, J, Moses, A. Local reaction secondary to insulin injection. A potential role for latex antigens in insulin vials and syringes. *Diabetes Care*. 18(8): 1195-7; Aug 1995.
6. Porte, D, Sherwin, R. Insulin injection complications: *Ellenberg & Rifkin's Diabetes Mellitus*. Second Edition, Stamford, Appleton & Lange: 1219-1220; 1997.
7. Middleton, E, Reed, C, Ellis, E, Adkinson, N, Yunginger, J, Busse, W. Factors affecting skin tests: *Allergy: Principles and Practice*. Fifth Edition, St. Louis, Mosby: 433-437; 1998.
8. Wood, R, Phipatanakul, W, Hamilton, R, Eggleston, P. A comparison of skin prick tests, intradermal skin tests and RASTs in the diagnosis of cat allergy. *Journal of Allergy and Clinical Immunology*. 103(5): 773-779; May 1999.
9. Lluch, B, Fernandez, M, Herrera, P, Sastre, J. Insulin lispro, an alternative in insulin hypersensitivity. *Allergy*. 54(2): 186-7; Feb 1999.
10. Kreines, K. Use of sheep insulin in insulin allergy. *Diabetes*. 20(11): 774-5; Nov 1971.

# 2001 Shuffield Award

The Arkansas Medical Society is seeking nominations for the 2001 Shuffield Award. The award will be presented at the AMS annual meeting in Hot Springs May 4-5.

The Shuffield Award is given each year to honor lay persons in Arkansas who have done outstanding work on behalf of community health care. Potential nominees include newspaper reporters, television personalities, government officials, teachers or volunteers in health-related programs. Physicians and members of their immediate families are not eligible to receive this award.

For an application, call the AMS at (501) 224-8967. or (800) 542-1058

Deadline is Feb. 28.



# Arkansas Department of Health HIV/AIDS Surveillance

## Summary

The cumulative total of HIV cases (1983-2000) is 4,833. Of that number, 2,924 meet the AIDS case definition. Of the 2,924 AIDS cases reported since 1983, 1,335 (46%) have died.

### HIV in Arkansas - September 30, 2000

Demographics	83-92	1993	1994	1995	1996	1997	1998	1999	2000	Total	%
Male	1,622	338	342	321	262	261	285	268	201	3,900	81
Female	288	89	89	89	77	92	70	85	54	933	19
Under 5	24	3	5	2	1	8	4	6	0	53	1
5-12	8	0	0	1	0	0	0	3	0	12	0
13-19	72	11	21	11	21	18	10	11	4	179	4
20-24	246	59	57	44	29	36	32	40	30	573	12
25-29	448	106	79	73	60	53	59	46	34	958	20
30-34	451	89	93	97	81	76	74	67	54	1,082	22
35-39	310	75	69	80	70	64	75	68	63	874	18
40-44	167	45	48	46	34	48	47	49	36	520	11
45-49	85	16	27	22	18	33	26	30	15	272	6
50-54	43	10	10	16	14	8	16	14	7	138	3
55-59	28	6	6	6	5	6	5	9	7	78	2
60-64	11	5	9	6	1	2	3	6	4	47	1
65+	17	2	7	6	5	1	4	4	1	47	1
White	1,234	264	243	252	186	179	185	191	138	2,872	59
Black	660	158	177	150	142	160	149	139	97	1,832	38
Hispanic	9	2	7	3	6	5	7	7	9	55	1
Other/Unknown	7	3	4	5	5	9	14	16	11	74	2
Male/Male Sex	1,049	230	213	176	153	133	163	152	94	2,362	49
Injection Drug User (IDU)	310	61	72	62	35	61	44	41	27	713	15
M/M Sex + IDU	185	30	24	29	26	19	14	12	11	351	7
Heterosexual/ Known Risk	235	96	96	75	77	91	64	66	38	838	17
Transfusion	40	1	2	5	2	1	2	1	0	54	1
Perinatal	24	3	5	3	1	8	4	6	0	54	1
Hemophiliac	35	2	3	5	0	0	2	0	0	47	1
Undetermined	32	4	16	55	45	40	62	75	85	414	9
Total	1,910	427	431	410	339	353	355	353	255	4,833	100

### AIDS in Arkansas - September 30, 2000

Demographics	83-92	1993	1994	1995	1996	1997	1998	1999	2000	Total	%
Male	807	325	253	235	213	179	173	159	139	2,483	85
Female	98	63	42	36	54	46	40	30	32	441	15
Under 5	16	2	1	2	0	8	4	1	0	34	1
5-12	3	0	0	2	0	0	2	1	0	8	0
13-19	9	4	3	1	4	2	2	1	0	26	1
20-24	61	31	22	11	14	11	12	7	11	180	6
25-29	206	78	45	46	46	29	31	20	14	515	18
30-34	217	96	80	73	75	51	43	37	35	707	24
35-39	178	77	52	49	54	55	50	41	42	598	21
40-44	99	48	40	35	37	35	28	37	34	393	13
45-49	54	26	22	17	20	20	19	23	13	214	7
50-54	21	10	12	14	5	6	15	7	12	102	4
55-59	21	8	5	7	7	4	1	7	7	67	2
60-64	7	5	10	5	1	1	4	4	3	40	1
65+	13	3	3	9	4	3	2	3	0	40	1
White	658	264	189	173	145	130	115	108	98	1,880	64
Black	237	120	103	95	116	89	86	70	60	976	33
Hispanic	5	3	2	3	4	3	6	2	7	38	1
Other/Unknown	5	1	1	0	2	3	6	9	6	33	1
Male/Male Sex	547	228	163	140	129	95	102	104	84	1,592	54
Injection Drug User (IDU)	114	68	48	47	28	50	36	20	20	431	15
M/M Sex + IDU	115	30	25	27	24	10	10	10	5	256	9
Heterosexual/ Known Risk	57	52	40	35	62	44	38	36	35	399	14
Transfusion	33	1	5	4	3	1	2	1	0	50	2
Perinatal	16	2	1	3	0	8	5	2	0	37	1
Hemophiliac	16	5	6	7	1	0	2	0	0	37	1
Undetermined	7	2	7	8	20	17	18	16	27	122	4
Total	905	388	295	271	267	225	213	189	171	2,924	100

## For More Information

HIV/AIDS Statistics Mischelle Priebe, (501) 661-2323

HIV Services: Renee Patrick, (501) 661-2292

www.healthyarkansas.com

## HIV Cases by County

County	1983-9-30-00	Jul 99-Jun 00	County	1983-9-30-00	Jul 99-Jun 00
Arkansas	24	*	Lee	21	*
Ashley	21	*	Lincoln	5	0
Baxter	38	4	Little River	19	4
Benton	130	9	Logan	10	*
Boone	35	*	Lonoke	30	*
Bradley	16	0	Madison	6	*
Calhoun	8	0	Marion	8	*
Carroll	45	*	Miller	123	6
Chicot	24	*	Mississippi	67	11
Clark	24	*	Monroe	20	*
Clay	4	*	Montgomery	7	0
Cleburne	16	0	Nevada	6	0
Cleveland	*	0	Newton	10	*
Columbia	26	*	Quachita	45	5
Conway	27	*	Perry	6	0
Craighead	93	10	Phillips	50	4
Crawford	44	4	Pike	*	0
Crittenden	217	17	Poinsett	16	0
Cross	26	*	Polk	14	*
Dallas	10	*	Pope	61	*
Desha	21	*	Prairie	6	0
Drew	15	*	Pulaski	1,573	92
Faulkner	70	5	Randolph	7	*
Franklin	12	*	St. Francis	95	8
Fulton	4	*	Saline	37	5
Garland	189	21	Scott	*	0
Grant	6	0	Searcy	5	0
Greene	25	0	Sebastian	269	17
Hempstead	27	*	Sevier	12	*
Hot Spring	27	*	Sharp	12	*
Howard	12	*	Stone	7	*
Independence	32	*	Union	155	11
Izard	10	*	Van Buren	7	*
Jackson	10	0	Washington	353	21
Jefferson	197	11	White	54	3
Johnson	11	0	Woodruff	4	0
Lafayette	9	0	Yell	16	*
Lawrence	14	*	Prisons	164	21

## AIDS Cases by County

County	1983-9-30-00	Oct 99-Sep. 00	Case Rate per 100,000	County	1983-9-30-00	Oct 99-Sep. 00	Case Rate per 100,000
Arkansas	10	*	12.1	Lee	14	*	23.6
Ashley	16	0	0.0	Lincoln	6	0	0.0
Baxter	25	*	3.0	Little River	10	*	15.3
Benton	91	*	2.2	Logan	9	0	0.0
Boone	27	*	3.1	Lonoke	25	*	2.0
Bradley	13	0	0.0	Madison	5	*	7.5
Calhoun	7	0	0.0	Marion	6	*	6.7
Carroll	28	*	4.4	Miller	73	11	28.0
Chicot	17	*	13.4	Mississippi	26	*	2.0
Clark	14	*	9.3	Monroe	11	*	10.0
Clay	*	*	6.0	Montgomery	5	0	0.0
Cleburne	10	0	0.0	Nevada	*	0	0.0
Cleveland	4	0	0.0	Newton	5	0	0.0
Columbia	18	*	4.1	Quachita	27	*	11.0
Conway	18	*	10.1	Perry	4	*	31.0
Craighead	56	4	5.2	Phillips	22	0	0.0
Crawford	34	4	7.8	Pike	*	0	0.0
Crittenden	115	9	18.0	Poinsett	8	0	0.0
Cross	12	0	0.0	Polk	10	*	5.1
Dallas	8	*	11.2	Pope	32	*	5.7
Desha	14	*	13.4	Prairie	7	0	0.0
Drew	9	*	5.7	Pulaski	962	58	17.0
Faulkner	54	*	2.4	Randolph	4	0	0.0
Franklin	8	*	6.0	St. Francis	45	5	18.0
Fulton	*	0	0.0	Saline	21	0	0.0
Garland	123	9	11.0	Scott	*	0	0.0
Grant	*	0	0.0	Searcy	5	0	0.0
Greene	13	*	2.7	Sebastian	174	24	23.0
Hempstead	14	*	5.0	Sevier	9	*	6.8
Hot Spring	23	*	10.3	Sharp	8	0	0.0
Howard	7	*	7.3	Stone	*	0	0.0
Independence	20	*	3.0	Union	86	10	22.2
Izard	9	*	7.6	Van Buren	6	*	6.4
Jackson	4	0	0.0	Washington	223	20	14.0
Jefferson	118	10	12.4	White	34	*	3.1
Johnson	7	0	0.0	Woodruff	5	*	11.4
Lafayette	6	0	0.0	Yell	12	*	10.6
Lawrence	14	*	5.8	Prisons	39	*	n/a

♦Denotes top ten case rates 08/99-09/00 \*Case numbers 1-3 are not indicated

# Older Female Inpatients in Arkansas

*The Relationship of Age to MDC, Mortality and Length of Stay in Older Female Inpatients in a Private, Nonprofit Hospital in Arkansas*



Melissa Johnson, MS — Lynette Duncan, MS — Andrea Rothenberger, M.ed., RN — Joanna Thomas, MD

## Abstract

The purpose of this study was to examine age and Major Diagnostic Categories (MDCs) and compare the variables to mortality and length of stay among inpatient women age 50 and over.

Archival statistical data were obtained for 2,238 inpatients in a private, nonprofit hospital in 1998. The ages ranged from 50 to 107 years old, with a mean age of 71.21 years.

Quantitative analyses were conducted to examine the data from a private, nonprofit hospital and determine if there were significant relationships between age, major diagnostic category, length of stay, and mortality in older women.

The MDC distribution indicated that the highest frequency of diseases and disorders were in the following three systems: circulatory system, musculoskeletal system and connective tissue, and the digestive system.

The average length of stay was 8.01 days. The 30-day readmission percentage and the 365-day readmission percentage were 12.24% and 28.02%, respectively. The mortality rate was 6%. In addition, 63.97% went home after discharge, and 67.07% were Medicare recipients.

The risk of musculoskeletal diseases and disorders increased with age ( $p=.0001$ ). The conditional probability of death was nearly nine times higher for the diseases of the nervous system, myeloproliferative diseases and disorders, poorly differentiated neoplasms and respiratory diseases.

As age increased, the probabilities of a long hospital stay decreased. The mortality analyses found that the lowest probabilities of survival were in categories of myeloproliferative diseases and disorders, poorly differentiated neoplasms, and infectious and parasitic diseases.

According to current health statistics, our society is getting older. Not only are people living longer, they are accessing more health care (American Association for World Health, 1999). Overall, the average life expectancy at birth has been identified at 76.5 years. The female has a longer life expectancy than the male, averaging 5.8 years longer. The highest life expectancy has been identified in the white female, who can expect to live to 79. The black woman has the second-highest life expectancy, 74.7 years.<sup>10</sup> Peters, Kochanek, and Murphy reported an all-time-low age-adjusted death rate for the United States and a continuing trend in the decline in mortality for all age groups.<sup>11</sup>

With a growing number of people living longer, there is a need to know about the most common health issues that affect quality of life. The top three national causes of death in older Americans were diseases of the heart, malignant neoplasms, and cerebrovascular diseases/stroke.<sup>11</sup> Arkansas health statistics mirror the national statistics. In April 1999, the Arkansas Department of Health reported that 30.5% percent of all female deaths were caused by heart disease. Malignant neoplasms were responsible for 20.1%, followed by cerebrovascular diseases at 10.8%.<sup>1</sup>

Other than three Connecticut hospital studies that explored the relationship of diagnosis code, mortality, and readmission, research is meager in this area.<sup>7,5,6</sup> There is a need for hospital-based research that addresses the diagnosis categories and the relationship to age and other variables.

## Purpose

The purpose of this study was to examine the most frequent diagnosis codes for women over 50 years old and to determine if there were significant relationships between age,



MDC, mortality, severity of illness, risk of mortality, and length of stay.

## Method

The subjects (n=2,238) were obtained through a hospital administrative database and abstracted from a proprietary decision-support software product. Archival data criteria were: 1998, inpatient, females, 50 years and older. The subjects had 3,255 inpatient visits to the hospital. The ages ranged from 50 to 107. Many of the patients were admitted to the hospital more than once within the calendar year. To avoid violating assumptions of independence in the statistical analysis, one observation per patient was obtained. This observation contained the final diagnosis category, severity of illness, and risk of mortality.

The length of stay for each patient was computed as her total length of stay within the year. All of the subjects had a discharge date on or between the calendar year dates of Jan. 1 to Dec. 31, 1998. Length of stay was chosen as an indicator to assess the mean length of stay of the subjects and to measure any associations between age, MDC, severity of illness, and risk of mortality.

The MDC categories were identified and analyzed with a frequency distribution.<sup>3</sup> The 30-day admission rate was used to calculate the readmission rate for the subjects. The 30-day readmission rate has been used as a quality-of-care indicator.<sup>8</sup> The ordinal severity of illness scores were based on the 3M Corp.'s proprietary APR-DRG methodology, which applies a 16-step, clinically driven algorithm to determine the value. The value rating was 0=Unknown, 1=Minimum, 2=Moderate, 3=Major, and 4=Catastrophic. The risk of mortality scores were also derived from the same methodology, which places heavy reliance on clinical parameters associated with the probability of death.<sup>2</sup>

The discharge disposition data were based on the site of care, subsequent to hospital discharge (i.e. home). The mortality data were assessed to calculate the mortality rate. The payor classes were collected to identify the major

insurance/payor sources (i.e. Medicare). The data were obtained in a Microsoft Excel spreadsheet and transferred to the SAS, Version 7.0, for statistical analysis.<sup>4</sup>

Univariate frequency distributions were used in the analysis. In addition, multivariate baseline-category logit models were used to study 1) the relationship between MDCs and age, risk of mortality, and severity of illness and 2) the relationship between discharge disposition and age, risk of mortality, and severity of illness.

Logistic regression models were used to study 1) the relationship between severity of illness and MDC and age and 2) the relationship between mortality and MDC, age, risk of mortality, and severity of illness. A Cox proportional hazards regression model was used to analyze the relationship between cumulative length of stay and age and MDC. This model takes mortality into account when considering length of stay.

## Results

Altogether, 2,238 subjects were included in this study. The mean age was 71.21 years old (SD + 12.00, range 50-107). The average length of stay was 8.01 days. The 30-day readmission percentage and the 365-day readmission percentage were 12.24% and 28.02%, respectively. The mortality rate was 6%. In addition, 63.97% of the subjects went home after discharge, and 67.07% of the subjects were Medicare recipients.

Out of 25 MDC categories, 73.51% of the diseases and disorders were found in the top five categories. The MDC distribution indicated that the five most frequent diseases and disorders were in the following areas: circulatory system (26.14%), musculoskeletal system and connective tissue (16.13%), digestive system (12.29%), respiratory system (11.62%), and nervous system (7.33%). (See Table 1)

The baseline-category logit model was used to understand the relationship between age and the MDCs. This model

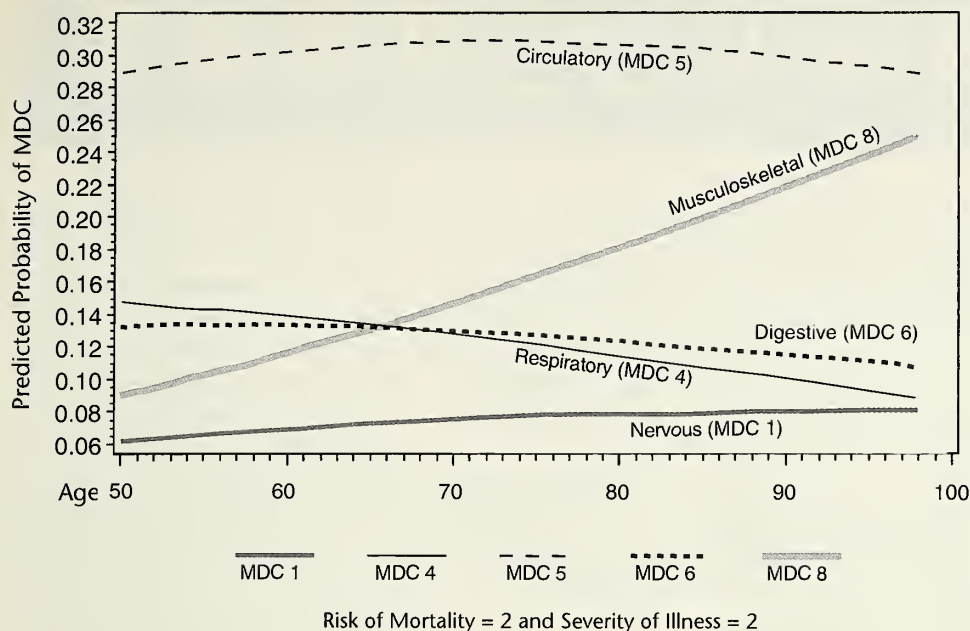
**Table 1.**

### MDC Frequencies in Relationship to Age in Female Inpatients over 50 in 1998.

Percent	MDC #	Human Body System, Diseases & Disorders Categories
26.14	5	Diseases & disorders of the circulatory system
16.13	8	Diseases & disorders of the musculoskeletal system & connective tissue
12.29	6	Diseases & disorders of the digestive system
11.62	4	Diseases & disorders of the respiratory system
7.33	1	Diseases & disorders of the nervous system
5.23	13	Diseases & disorders of the female reproductive system
3.26	7	Diseases & disorders of the hepatobiliary system & pancreas
3.17	9	Diseases & disorders of the skin, subcutaneous tissue & breast
2.82	18	Infectious & parasitic diseases, systemic or unspecified sites
2.77	10	Endocrine, nutritonal & metabolic diseases & disorders
2.73	11	Diseases & disorders of the kidney & urinary tract
1.61	19	Mental diseases & disorders
0.94	3	Diseases & disorders of the ear, nose, mouth & throat
0.94	0	No MDC assigned
0.89	21	Injuries, poisonings & toxic effects of drugs
0.67	16	Diseases & disorders of blood, blood forming organs, immunological disorders
0.63	17	Myeloproliferative diseases & disorders, poorly differentiated neoplasm
0.45	23	Factors influencing health statistics & other contacts with health services
0.22	24	Multiple significant trauma
0.18	2	Diseases & disorders of the eye

Category descriptions were based on The 1997-98 DRG Pocket Resource Guide. 1997.

**Figure 1. Predicted Probability of MDC in Relationship to Age**



revealed a significant relationship between the MDC, age, severity of illness, and risk of mortality ( $p=.0001$ ). The model was appropriate for the data (lack of fit  $p\text{-value} \geq 1$ ). In this model, the parameter estimates that were found not to be significantly different from 0 were set to zero. A fixed moderate rating value was used for the risk of mortality and severity of illness to identify the systems' predicted probability of MDC.

The probability of a subject having a circulatory system disorder or disease was the highest, at a probability of .30778. (See Figure 1) While the diseases of the respiratory system decreased with age (.14617 to .08831), the diseases of the musculoskeletal system increased with age (.08928 to .25012). In addition, diseases and disorders of the nervous system increased slightly, and diseases and disorders of the digestive system decreased slightly.

The diagnosis categories and age had an effect on the length of stay based on the Proportional Hazards Regression Model. Indicator variables were assigned for each level of MDC, and these variables and age were included in the model. Backward selection was used to determine which of these variables should remain the final model. Age and seven MDC

categories were the only variables that showed a relationship to length of stay.

The MDC categories of the nervous system, myeloproliferative diseases and disorders, poorly differentiated neoplasm, and the respiratory system had equal parameters. These MDCs had the lowest probability of a long length of stay. Subjects in these MDCs had the highest Hazard Ratio at 8.947. The risk of dying for these subjects were over 8 times higher than all of the MDCs that were found to be significant in this study. The parameter estimates showed

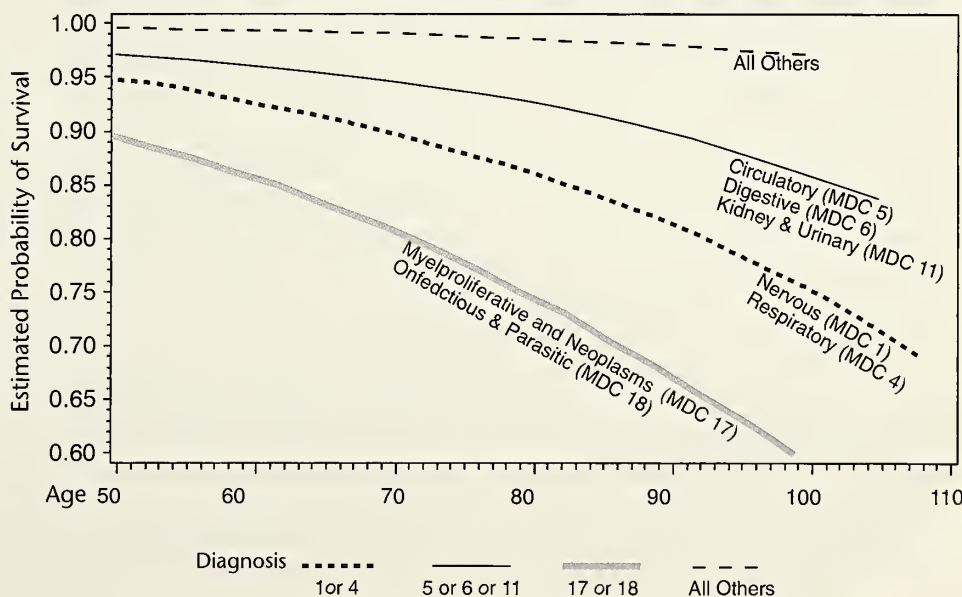
that as age increases, the probability of a long hospital stay decreases.

The MDCs of the circulatory system, digestive system, diseases and disorders of the kidney and urinary tract had equal parameters (Hazard Ratio 4.763). The two remaining MDC categories were infectious and parasitic diseases and the "other" group. The "other" contained all the other MDCs that were not represented above. The highest probability of a long length of stay was in the "other" category. The inclusion of the indicator variable for infectious and parasitic diseases violated the proportional hazards assumption, so the analysis was

completed by excluding this indicator from the model and stratifying the data by it. The subjects who were in the seven identified categories had a lower probability of a long hospital stay than the subjects in the "other" MDCs.

The stepwise logistical regression model determined that the estimated probability of survival was related to age and MDC. Figure 2 shows the relationship between age, diagnosis, and mortality. The grouped MDC values in terms of the effect on mortality were not statistically different for mortality. The lowest probability of survival was in

**Figure 2. The Relationship between Age, Diagnosis and Mortality.**





these categories: myeloproliferative diseases and disorders, poorly differentiated neoplasm, infectious and parasitic diseases, and systemic or unspecified sites.

The highest probability of survival occurred in the "other" category. Equal parameters grouped MDCs: circulatory system, digestive system, and the kidney and urinary tract. Another group of the nervous system and the respiratory system was created. The lowest risks were in the "other" category. The lack-of-fit p-value for the model was .8842. MDCs were grouped due to the fact that they were not significantly different in terms of the effect on mortality.

Stepwise logistic regression was used to determine a relationship between age, diagnosis and the severity categories. The lack-of-fit p-value was .9827. The probability of a more severe diagnosis increases with age in all MDCs. In addition, a baseline-category logit model was used to determine an association of discharge to age ( $p=.0001$ ). The model found that as one gets older, the probability of going home decreases.

### Discussion

It is interesting that more than half (54.56%) of the diseases and disorders were in the top three MDCs (circulatory, musculoskeletal/connective tissue, and the digestive system). The MDCs were chosen over the diagnosis-related groups (DRGs) because of the limited number of reference categories. While there were 25 MDCs, there are more than 500 DRGs.

The distribution of the MDCs was not the same across the ages. Age, severity of illness, and risk of mortality were found to affect the distribution. Circulatory diseases were the highest, which has been shown in the national and state statistics. The risk of musculoskeletal diseases and disorders increased with age.

The mortality analysis found that the lowest probability of survival was in categories of myeloproliferative diseases and disorders, poorly differentiated neoplasms, and in-

fectious and parasitic diseases. This supports the fact that these diseases are more fatal as one ages. A comparison of MDC, age, and mortality indicated that the probability of survival decreases with age.

The probability of a more severe diagnosis increased with age, and, as age increased, the probability of going home decreased. This supports NCHS (1996), which reported that as age increased, the rates of discharge and procedures increased. The conditional probability of death was nearly 9 times higher for the diseases of the nervous system, myeloproliferative diseases and disorders, poorly differentiated neoplasms, and respiratory diseases. As age increased, the probability of a long hospital stay decreased.

### Conclusions

This study shows a relationship of age and MDC in comparison to mortality, length of stay, and severity. The results of this study support the need for more research and education in the areas of circulatory and musculoskeletal diseases and disorders in women. Also, there should be more hospital-based research that addresses the diagnosis categories and the relationship to age and other variables. Indeed, we do have national and state statistics. Yet, examining and sharing the results of the data that each hospital have at their disposal could teach us even more. ■

*Johnson is a doctoral student and health educator at the University of Arkansas. Duncan is a statistical consultant with the University of Arkansas. Rothenberger is quality management director with Washington Regional Medical Center. Dr. Thomas is an assistant professor in the department of family and community medicine at the University of Arkansas for Medical Sciences in Little Rock.*

### References

1. Arkansas Department of Health. (1999). *Mortality in Arkansas: 1997*. Center for Health Statistics and Division of Vital Records. Little Rock, Ark.
2. Computer Sciences Corporation Healthcare Group. (1997). Users

Guide for the Comparative Benchmark Analysis Software. Framingham, Mass.

3. CHIPS. (1997). *The 1997-98 DRG Pocket Resource Guide*. The Center for Healthcare Industry Performance Studies. Columbus, Ohio.
4. Hatcher, L. and Stephanski, E.J. (1994). *A step-by-step approach to using the SAS system for univariate and multivariate statistics*. North Carolina: SAS Institute.
5. Hennen, J., Krumholz, H.M., and Radford, M.J. (1995a). Mortality experience, 30 days and 365 days after admission, for the 20 most frequent DRG groups among Medicare inpatients aged 65 or older in Connecticut hospitals, fiscal years 1991, 1992, and 1993. *Connecticut Medicine*, 59 (3), 137-142.
6. Hennen, J., Krumholz, H.M., and Radford, M.J. (1995b). Twenty most frequent DRG groups among Medicare inpatients age 65 or older in Connecticut hospitals, fiscal years 1991, 1992, and 1993. *Connecticut Medicine*, 59 (1), 11-15.
7. Hennen J., Krumholz, H.M., Radford, M.J., and Meehan, T.P. (1995). Readmission rates, 30 days and 365 days postdischarge, among the 20 most frequent DRG groups, Medicare inpatients aged 65 or older in Connecticut hospitals, fiscal years 1991, 1992, and 1993. *Connecticut Medicine*, 59 (5), 263-270.
8. Marcantonio, E.R., McKean, S., Goldfinger, M., Kleefield, S., Yurkofsky, M., and Brennan, T.A. (1999). Factors associated with unplanned hospital readmission among patients 65 years of age and older in a Medicare managed-care plan. *The American Journal of Medicine*, 107 (1), 13-16.
9. National Center for Health Statistics. (1999a). *Ambulatory and inpatient procedures in the United States, 1996* (PHS Publication No. 98-1798 pp.124).
10. National Center for Health Statistics. (1999b). *Deaths: Final Data for 1997*. 47 (PHS Publication No. 19-018 pp. 108).
11. Peters, K.D., Kochanek, K.D., and Murphy, S.L. (1998). *Deaths: Final data for 1996*. *National Vital Statistics Reports*, 47 (9), 1-100.

# PEOPLE+EVENTS

## RETIREMENT

### **Sheridan Physician Honored at Retirement**

Dr. Jack Irvin of Sheridan was honored Nov. 4 by the residents of Grant County on the occasion of his retirement. Friends, patients and family members paid tribute to Dr. Irvin for his 53 years of service to the community.

In addition, Sheridan Mayor Joe Wise declared Nov. 13 — Dr. Irvin's birthday and the date of his retirement — Dr. Jack Irvin Day.

Dr. Irvin graduated from Sheridan High School in 1938. He continued his education at Henderson State University in Arkadelphia, the University of Arkansas for Medical Sciences and Baylor University Hospital in Dallas. He completed his residency in pathology at Bowman Gray Hospital in Winston-Salem, N.C.

Dr. Irvin began his practice in Sheridan in 1947, at times practicing out of his home. In 1956, he built his clinic on High Street.

He and his wife, Marge, have three children and three grandchildren.

## HONORED

### **Boone County Doctors Honor Elected Officials**

The Boone County Medical Society hosted its annual appreciation dinner for area elected officials in November. Randy Laverty, outgoing chairman of the

Public Health, Welfare and Labor Committee of the state House, received a plaque from the Society and the Arkansas Academy of Family Physicians. Attendance at the dinner was 86.

### **Chamber Honors Searcy Doctor**

Dr. Porter Rodgers Jr. has received the Medical Professional of the Year Award from the Searcy Chamber of

Commerce Quality of Life Committee. Dr. Rodgers was chosen for his contributions to the health and quality of life of residents of Searcy. The award was presented at the committee's annual banquet Nov. 20.

### **Physicians Receive Awards from AMA**

Each month, the American Medical Association presents the Physician's

Recognition Award to those who have completed acceptable programs of continuing education.

AMA recipients for November are Dr. Roger Willis Alderson of Rogers, Dr. Carlos Anaya of El Dorado, Dr. James Henry Arkins of Bentonville, Dr. Joe Henry Dorzab of Fort Smith, and Drs. Frank Hsioh-ti Ma and Josue Montanez of Little Rock.

## OBITUARIES

### **Donald G. Browning Sr., MD**

Dr. Donald G. Browning Sr., 64, died Dec. 2.

Dr. Browning, a retired gastroenterologist, was a graduate of Hope High School, Henderson State University at Arkadelphia and the University of Arkansas for Medical Sciences. His internship was at Brooke Army Hospital in San Antonio, and his residency was at Fort Benning, Ga. He completed a GI fellowship at UAMS in 1970-71.

After serving in the Army in Germany and attaining the rank of major, he entered private practice in Little Rock with Dr. Jerome Levy and Dr. T.J. Smith.

In 1971, Drs. Browning and Smith founded Gastroenterology Associates PA, the first GI subspecialty practice in Arkansas. They, along with Dr. Robert C. Power, were instrumental in developing gastrointestinal laboratories at St. Vincent Infirmary Medical Center, Baptist Medical Center and Baptist Memorial Medical Center.

Dr. Browning was also a member of the American Medical Association, the Pulaski County Medical Society and the American Society of Gastrointestinal Endoscopy. He was a fellow of the American Society of Addiction Medicine, through which he worked with physicians and others who struggled with alcoholism or drug addictions.

Survivors include his wife, Jo Ann Russell

Browning; his mother, Floyce Browning; two sons and daughters-in-law, Dr. Don and Sundee Browning Jr. of Atlanta; Dan and Tara Browning of Germantown, Tenn.; one daughter and son-in-law, Joan and Mike Foster of Atlanta; three brothers and sisters-in-law, Conrad and Polly Browning of Little Rock, Bill and Sandra Browning of Emmett, Ark., and the Rev. Jerry and Ann Browning of Magnolia; a sister-in-law, Jutta Browning of Aurora, Colo.; and eight grandchildren.

He was preceded in death by his father, Grady Browning, and his brother, Maj. Larry Browning.

### **Evans Z. Hornberger Jr., MD**

Dr. Evans Z. Hornberger Jr., 82, died Dec. 1 in Fort Smith.

From 1946-50, Dr. Hornberger studied and practiced internal medicine in Milwaukee. He then moved to Fort Smith, where he had a private practice from 1950-75. He served as medical director of Sparks Regional Medical Center from 1975-86. He retired in 1986.

He was also a member of the American Medical Association and the Sebastian County Medical Society.

Born in Omaha, Neb., Dr. Hornberger graduated from the University of Nebraska College of Medicine in 1942. He served in the Army from 1943-46 and was discharged after attaining the rank of major. He served with the 16th Armored Division at Fort



Chaffee and with the 35th Infantry Division in Europe in World War II. He was wounded in action and received a Purple Heart and a Bronze Star.

He was an elder and trustee of the First Presbyterian Church in Fort Smith and a volunteer for several charitable organizations, including Meals on Wheels.

He is survived by his wife, Nancy Eads Hornberger; his son and daughter-in-law, Robert E. and Pam Hornberger of Fort Smith; his daughter and son-in-law, Ellen and Conrad Masterson Jr. of Houston; one brother and sister-in-law, Dr. John and Joan Hornberger of Manning, Iowa; four grandchildren; and two great-grandchildren. ■

## New Members

**Donna M. Graham, MD**  
Specialty: PDA  
10310 W. Markham St., #222  
Little Rock, AR 72205  
(501) 227-5589

**Ehsan M. Hadi, MD**  
Specialty: Resident-FP  
4010 Mulberry St.  
Pine Bluff, AR 71603  
(870) 541-6010

**Martin A. Hannon, MD**  
Specialty: Resident-FP  
612 S. 12th St.  
Fort Smith, AR 72901  
(501) 785-2431

**Sally S. Harms, MD**  
Specialty: Resident-PTH  
4301 W. Markham St.  
Little Rock, AR 72205  
(501) 686-5444

**Paul T. Harrington, MD**  
Specialty: ID  
6801 Rogers Ave.  
Fort Smith, AR 72913  
(501) 478-3580

**Scott Harton, MD**  
Specialty: Resident-FP  
460 W. Oak St.  
El Dorado, AR 71730  
(870) 862-2489

**James M. Hawk, MD**  
Specialty: GP  
W. 715 Sherman  
Harrison, AR 72601  
(870) 741-8247

**Prabhat K. Hebbar, MD**  
Specialty: Resident-IM  
4301 W. Markham St.  
Little Rock, AR 72202  
(501) 686-5162

**Muhannad M. Heif, MD**  
Specialty: Resident-IM  
4710 Sam Peck Road, #2148  
Little Rock, AR 72223

**John K. Heifner, MD**  
Specialty: NPH  
500 S. University Ave., #219  
Little Rock, AR 72205  
(501) 664-9881

**Brent E. Holt, MD**  
Specialty: Resident-FP  
2907 E. Joyce Blvd.  
Fayetteville, AR 72703  
(501) 521-8260

**Michael Tzuoh Hong, MD**  
Specialty: OBG  
3104 Apache Drive  
Jonesboro, AR 72401  
(870) 972-8788

**Hossam Ibrahim, MD**  
Specialty: END  
180 Medical Park, #202  
Hot Springs, AR 71901  
(870) 625-7400

**Phillip C. Jackson, MD**  
Specialty: Resident-FP  
2907 E. Joyce Blvd.  
Fayetteville, AR 72703  
(501) 521-8260

**Jana M. Jaderborg, MD**  
Specialty: GS  
724 Deaver St.  
Springdale, AR 72764  
(501) 751-3202

**William M. James, MD**  
Specialty: Resident-IM  
4301 W. Markham St.  
Little Rock, AR 72205  
(501) 686-5444

## ARKANSAS EMERGENCY MEDICINE OPPORTUNITIES NOW AVAILABLE.

- ✓ BC/BP Emergency Medicine or Primary Care Physicians.
- ✓ Residents welcome at some facilities.
- ✓ Primary & Supplemental Coverage.
- ✓ Annual volumes range 6,300 to 35,000.
- ✓ Locations include Little Rock, Heber Springs, Walnut Ridge, Wynne & Jonesboro.
- ✓ **Directorship needed in Walnut Ridge.**
- ✓ Overwhelming recreational and cultural opportunities available.

For information on these and other Arkansas opportunities, contact:

**Traci Mahlmeister,**  
*Physician Recruiter*

**800-476-5986**

**Fax: 919-382-3274**

**tmahlmei@phyamerica.com**

www.phyamerica.com

*All inquires confidential.*

*PhyAmerica maintains flexible schedules for its Independent Contractors along with competitive remuneration and procured malpractice insurance.*



**PhyAmerica**  
Physician Services, Inc.



## Ridgecrest Resort on Bull Shoals Lake

For some of the best views of Bull Shoals Lake and the Ozark Mountains, visit Ridgecrest Resort in Midway. Located 15 minutes from Mountain Home, this scenic spot offers a host of amenities for the traveler looking to get away from it all.

Cottages feature a fully equipped kitchen, cable television, barbecue kettles and lawn chairs. Visitors also can enjoy fantastic views from the comfort of their cottage.

A play area and game room will keep the kids busy with swings, outdoor toys, two video games, a ping-pong table and board games. The common area has a large deck, barbecue grill and seating. Visitors can take a short walk to the swimming dock or soak in the indoor hot tub.

Visitors are welcome to bring their own boat or to rent one when they arrive. Ridgecrest has two pontoons and several fishing boats for rent, either for four and six hours or by the week. Daily

prices range from \$20-\$85, with weekly rates from \$120-\$450.

Honeymooners, or couples just wanting a little extra pampering, can stay in the honeymoon suite, which has a fireplace, Jacuzzi and private deck.

Nearby Mountain Home offers conveniences such as grocery stores and restaurants, as well as movie theaters and two 18-hole golf courses.

For those wanting a little city life along with the scenic beauty, Branson, Mo., with its live music and shopping malls, is two hours away.

Daily rates for cottages range from \$58-\$64 for one bedroom, \$73 for two bedrooms and \$102 for three bedrooms. The honeymoon suite is \$85 a day. Weekly rates also are available. ■

*Ridgecrest Resort, 971 Howard Creek Road, Midway, Ark. 72651. For information, call (870) 431-5376 or visit [www.bullshoals.com/ridgecrest](http://www.bullshoals.com/ridgecrest).*





## ADVERTISERS INDEX

AMS Benefits Inc. ....	300
Arkansas Business.Com .....	Back cover
Arkansas Financial Group Inc., The .....	296
Arkansas Foundation for Medical Care ....	Inside front cover
Asti, William Henry, AIA .....	299
Central Flying Service .....	308
Farmers Insurance Group .....	308
Fiser Hummer .....	296
Little Rock Medical Associates .....	309
Maggio Law Firm .....	322
Medical Practice Consultants Inc. ....	309
MedPlus Quotes .....	299
Metropolitan National Bank .....	298
Micheal Munson, A.G. Edwards & Sons Inc. .	Inside back cover
PhyAmerica Physician Services Inc. ....	320
Practice Plus .....	310
Pro Travel .....	298
State Volunteer Mutural Insurance Co. ....	295
Washington Regional Medical Center .....	310

Special Publications  
Publisher  
*Brigette Williams*

Special Publications  
Editor-in -Chief  
*Natalie Gardner*

Managing Editor  
*Shelby Brewer*

Copy Editor  
*Donna Schratz*

Editorial Assistant  
*Susan Van Dusen*

Sales Manager  
*Stephanie Hopkins*

Account Executives  
*Jason Carson*  
*Liz Earlywine*

Director of Design  
and Circulation  
*Virgeen Healey*

Director of Marketing  
*Allison Pickell*

Production and Circulation  
Coordinator  
*Jeremy Henderson*

Editorial Art Director  
*Irene Forbes*

Photographer  
*Mark Wilson*

Advertising Coordinator  
*Kristen Heldenbrand*

Marketing Assistant  
*Mitzi Tiffie*

Database Administrator  
*Andrea Martin*

Advertising Assistant  
*Greg Duszota*



**ARKANSAS BUSINESS  
PUBLISHING GROUP**

Chairman & Chief Executive Officer  
*Olivia Farrell*

President and Publisher  
*Jeff Harkins*

Executive Vice President  
*Sheila Palmer*

© 2001 Arkansas Business Publishing Group  
[www.abpg.com](http://www.abpg.com)

## Collect Bad Debt

- Cheaper
- Faster
- In compliance with the Law



# MAGGIO LAW FIRM

*your collection law firm*

Offices in Conway and Searcy • 1-800-600-3201

[www.ebaddebt.com](http://www.ebaddebt.com)

If you've always used a  
collection agency. . . WHY?

Cut out the collection agency by  
retaining the Maggio Law Firm.

Save time. Save money.  
Be in compliance with the law.

Have you always used a collection  
agency because "that's the way  
you've always done it?"

*Try a new way. . . tip the scales in  
your favor, call today.*



# 2001 Investment Outlook:

## *The Bull Should Have More Room To Run*

Contributed by:  
Micheal D. Munson  
Senior Vice President—Investments  
A.G. Edwards  
1501 N. University, Suite 100  
(501) 664-9135

**W**ithout a doubt the year 2000 has been turbulent for the financial markets. While the major stock market indexes enjoyed huge gains early in the year, the reality of slower earnings growth, higher energy prices and presidential election turmoil all helped the market head south. Along with these issues, the Federal Reserve raised interest rates to slow a red-hot economy and prevent probable inflation, which scared already-nervous investors. So what does 2001 hold in store for the economy and the market? Here's one set of perspectives:

ing into 2001 its growth should also continue. Some experts expect the real gross domestic product (GDP) to grow approximately 2.9% compared to an average yearly growth of 4.5% for the previous four years. Analysts have projected a slower economy in the first months of the year with a moderate strengthening later in 2001. Meanwhile inflation as measured by the Consumer Price Index is expected to drop to 2.5% in 2001, down from 3.3% in 2000.

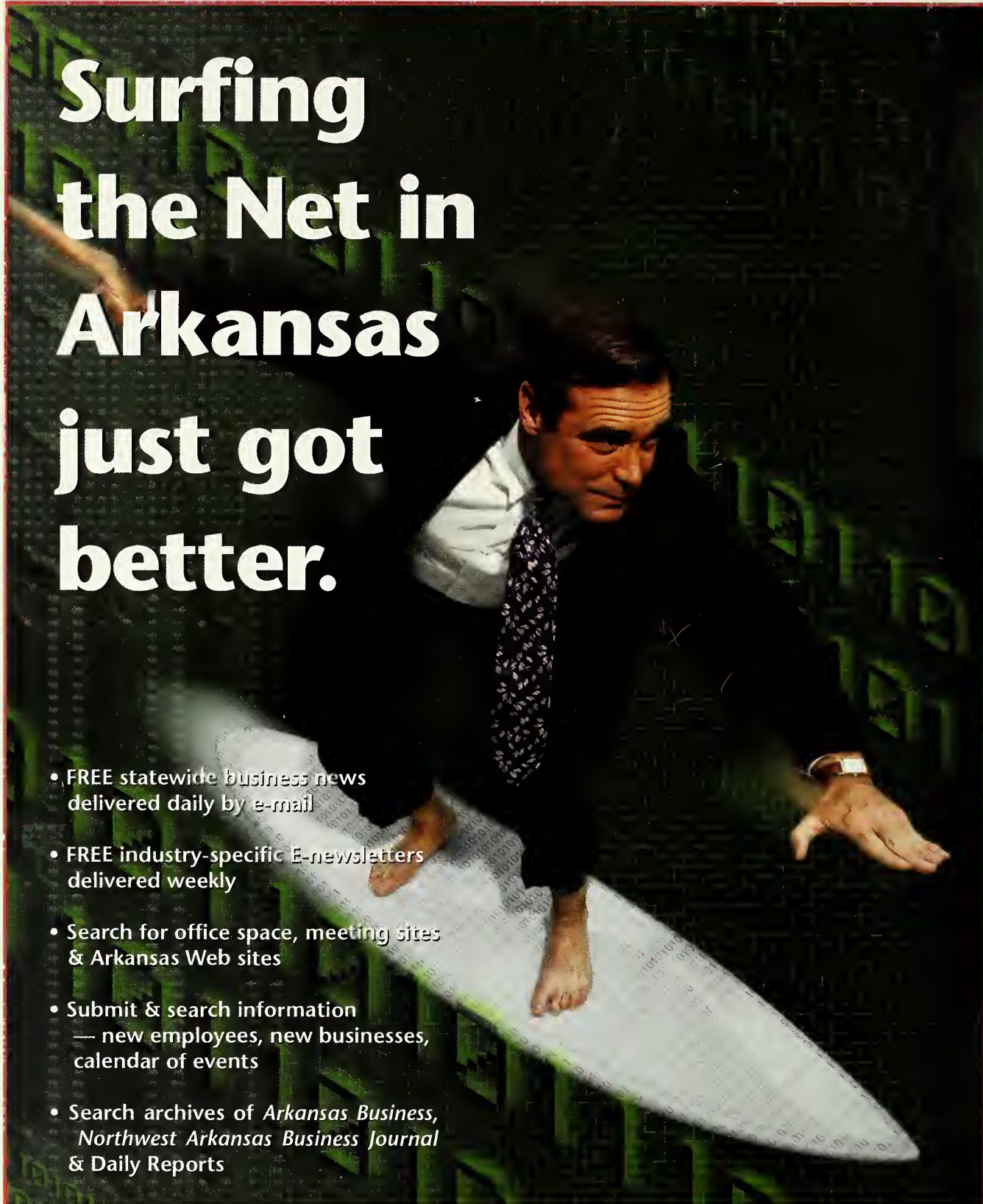
- **History Forecasts Lower Interest Rates.** The Federal Reserve, once concerned with an overheating economy, has seen the pace of activity slow in the latter part of 2000. This means we will most likely see the Fed cut interest rates, probably early in the year. Why? The economy historically endures three stages during a slowdown. The first stage is after a peak in economic momentum when the Fed has raised interest rates to prevent rapid economic growth from triggering higher inflation. The second is a continuation of a slowdown while economic growth is moderating. The current U.S. economy is likely to be in the third stage in the beginning of 2001. In this stage the economy experiences a considerable slowdown and the Fed recognizes it no longer needs to be restrained by high interest rates. The Fed typically cuts interest rates in this third stage to re-stimulate the economy to a healthy pace of growth. While past performance cannot guarantee future results, the last time we saw this type of economy was in 1995, which was a good year for the financial markets.

- **Stocks Expected To Rebound.** After 18 months of stock market corrections some experts believe we are finally entering a season of recovery. Thanks to a more benign economy, lower interest rates, continued earnings growth and healthier valuation levels, the stock market should be a good place to be for investors in 2001. Investors can look for selected opportunities in the technology, healthcare and financial areas.

- **Bonds Look Good Too.** Because long-term interest rates should decline as the Fed is expected to cut short-term rates, municipal and corporate bonds are also expected to present attractive opportunities. Here's hoping 2001 brings you many great returns. Just remember that no matter what the markets may do in short term, it's important to always remember your long-term investment goals and your plan for achieving those goals.



# Surfing the Net in Arkansas just got better.

A man in a dark suit, white shirt, and patterned tie is surfing on a large, white, wave-like shape that resembles a computer keyboard or a stylized '1' and '0' pattern. The background is dark with green, glowing binary code (0s and 1s) floating around. The man is looking down at the wave, and his hands are outstretched for balance.

- FREE statewide business news delivered daily by e-mail
- FREE industry-specific E-newsletters delivered weekly
- Search for office space, meeting sites & Arkansas Web sites
- Submit & search information — new employees, new businesses, calendar of events
- Search archives of *Arkansas Business*, *Northwest Arkansas Business Journal* & Daily Reports

The State's #1  
Source for  
**Arkansas**  
Business Information



ARKANSAS  
BUSINESS.COM

For sponsorship opportunities, contact Jeff Hankins  
at 372-1443 or [jhankins@abpg.com](mailto:jhankins@abpg.com)

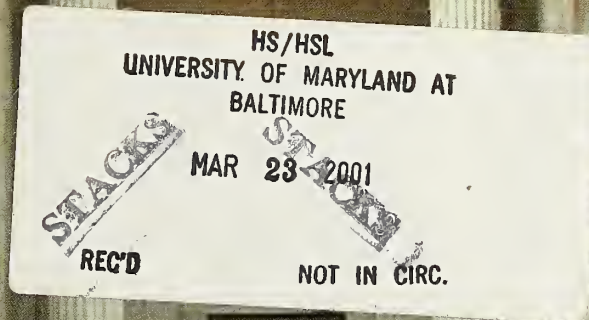


# THE Journal

OF THE ARKANSAS MEDICAL SOCIETY

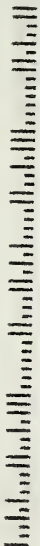
Vol. 97 No. 10

April 2001



\*\*\*\*\*MIXED ADC 640 554 P4

HEALTH SCIENCES LIBRARY  
UNIVERSITY OF MARYLAND  
COLLECTION DEVELOPMENT DEPT.  
601 W LOMBARD ST  
BALTIMORE MD 21201-1512



## Day at the Capitol

Physicians Take Their Concerns to the Legislature



In your job every decision is

CRUCIAL

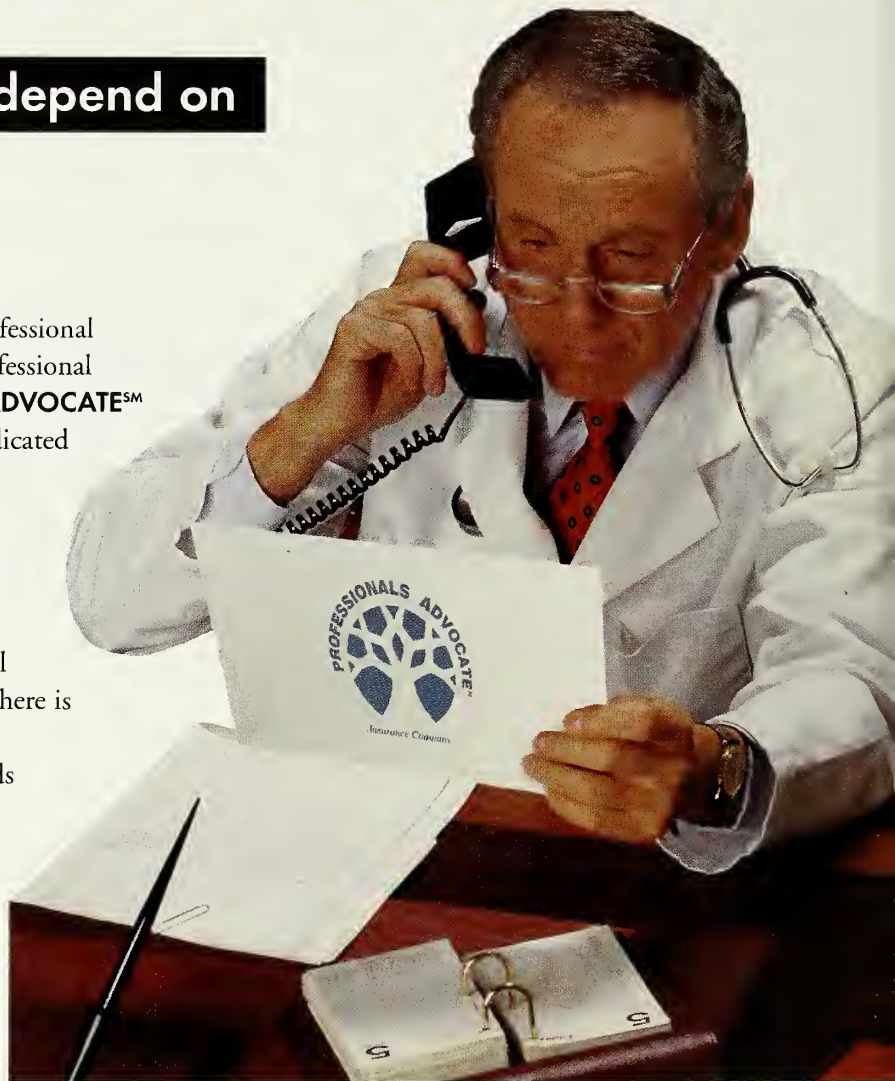
That's why you should depend on

## PROFESSIONALS ADVOCATE<sup>SM</sup>

If you want to make the right choice for your professional liability insurance, start by choosing the right professional liability insurance company. **PROFESSIONALS ADVOCATE<sup>SM</sup> (ProAd)** is a physician-owned liability insurer dedicated to the long-term defense of your career.

**ProAd** was founded by one of the oldest and most respected physician-owned and directed liability insurance companies in the country. This legacy gives us a solid foundation of financial resources, stability and experience. And, because there is direct physician involvement in the decisions that affect you, we are sensitive to the special needs of physicians and have a genuine commitment to protecting your reputation and practice.

Let **ProAd** be your advocate. Call today for additional information and a no-obligation quotation from a **ProAd** Agent conveniently located near you.



## The ProAd Advantage

- Quality coverage for all specialties at competitive prices from a financially stable physician-owned insurer.
- Free Tail coverage upon your full retirement with no age requirement, following one full year of continuous claims-made coverage with **ProAd**.
- Absolute Consent to Settle provision.
- New Practitioner discount.
- Full Prior Acts Coverage available.
- Aggressive claims defense policy. Top local attorneys specializing in medical malpractice defense.
- Defendant's reimbursement coverage. All covered attorney fees and defense-related expenses associated with the investigation paid by **ProAd**.
- Prompt and responsive service.
- Knowledgeable local agents selected for their health care expertise.
- MedGuard Defense Coverage with a limit of \$25,000 for defense of administrative or judicial proceedings included at no additional charge.



**Professionals Advocate<sup>SM</sup>**  
[www.weinsuredocs.com](http://www.weinsuredocs.com)

Arkansas Agent: Rebsamen Insurance  
1500 Riverfront Drive, P.O. Box 3198  
Little Rock, AR 72203  
501-661-4800 • 501-666-9592 Fax

# Enhance The Benefits of Your Charitable Gifts

Contributed by:

Micheal D. Munson

Senior Vice President-- Investments

A.G. Edwards

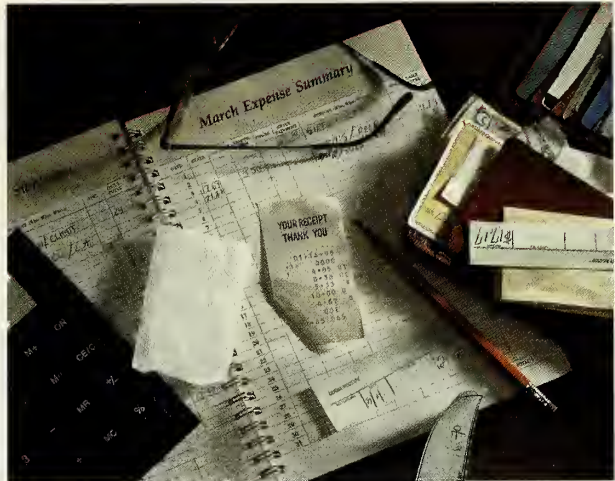
1501 N. University, Suite 100

(501) 664-9135

Americans provide billions of dollars in support each year to charities and other nonprofit organizations. You may be one of them. The reasons for this generosity are usually for personal fulfillment and social obligation. But tax laws also provide considerable incentives for individual charitable giving and gaining an understanding of these laws is the first step toward making the most of your charitable donations.

In general, tax laws allow you to deduct an amount equal to the value of charitable contributions made during your lifetime, as long as you itemize deductions. Therefore, your annual cost of giving generally equals the value of the property donated less the tax savings. Keep in mind however, that the tax law also establishes certain limits regarding charitable gift deductions. The amount you can deduct in any one year depends on the type of charity to which you donate, the type of property contributed and the way the charity uses the gift.

Various investments offer an array of features that can help enhance the positive effects of your charitable giving, both for the charity and for you. One way to make charitable contributions at the lowest after-tax cost is by donating appreciated securities instead of cash. By donating stock, for example, you can generally obtain a deduction for the current market value of the stock and avoid paying taxes on the capital gain you would have realized if you had sold the stock and donated the proceeds. As always, you should consult your tax adviser before you make any tax related investment decisions.



If you choose to make gifts of tax-deferred assets, such as IRAs, annuities or retirement plan accounts, special rules may apply. Gifts of these types of assets during your lifetime usually trigger an income tax liability as if you had simply made a withdrawal. You will get some amount of deduction for your gift, but it will not usually protect the entire amount. In contrast, naming a charity as beneficiary of a tax-deferred account upon your death could be beneficial. You avoid the potential for "double taxation" (income and estate taxes) on the portion you give.

Another way to make a charitable contribution is through a charitable trust. The charitable trust consists of two parts of property, the income interest and the remainder interest. The income interest is the right to receive income payments during the term of the trust and the remainder interest is the property remaining when the income interest is completed according to the terms of the trust. With a charitable trust, you can receive estate and/or income tax deductions by donating either the income or the remainder interest, while keeping the other part for yourself or your heirs.

To enhance the benefits of your charitable giving, you should consider all the alternatives. Your tax adviser can provide more information about these and other charitable giving strategies and can help you determine which methods are most appropriate for your situation- Your financial consultant can also help you in establishing trusts or choosing appropriate securities for your investment needs.

**This article was provided by A.G. Edwards & Sons Inc., Member SIPC.**



# ***RISING TO THE CHALLENGE***

AFMC'S EIGHTH ANNUAL QUALITY CONFERENCE

- ▲ Clinical Priorities
- ▲ Quality Improvement
- ▲ Patient Safety
- ▲ Public Policy
- ▲ Long-Term Care
- ▲ Compliance Issues



## **Speakers Include Local and National Experts**

### **Including John Nance**

- ▲ *New York Times* best-selling author
- ▲ "Good Morning America" Aviation Editor
- ▲ Airline Pilot
- ▲ Board member, National Patient Safety Foundation

To Register Call AFMC (501)649-8501 ext 204

# THE Journal

OF THE ARKANSAS MEDICAL SOCIETY

Winner of the ASAE Excellence in Communications Award

## CONTENTS

### FEATURES

#### 335 Cigarette Smoking Bills Are a Major Focus at "Day at the Capitol"

At the Arkansas Medical Society's "Day at the Capitol" on Jan. 31, doctors, spouses, medical students and clinic managers from across the state voiced their views on important legislative issues relating to public health.

#### 338 A Long Journey

Drs. Parthasarathy Vasudevan, a urologist, and wife Kanaka Vasudevan, an anesthesiologist, describe the path that led them from India to Helena, Ark., and the challenges of being both married and doctors.

#### 351 Pediatric Injuries Resulting from Use of All-Terrain Vehicles

Each year, 20,000 children are injured while operating all-terrain vehicles. Although ATV injury information in Arkansas is limited, our special article examines the high injury rates in the 75 Arkansas counties on the basis of prehospital emergency encounter reports.

### DEPARTMENTS

#### 331 Commentary Lee Abel, MD

#### 333 What We've Done For You Lately

#### 340 Loss Prevention

#### 343 Cardiology Report

#### 346 Radiology Report

#### 349 A Closer Look at Quality

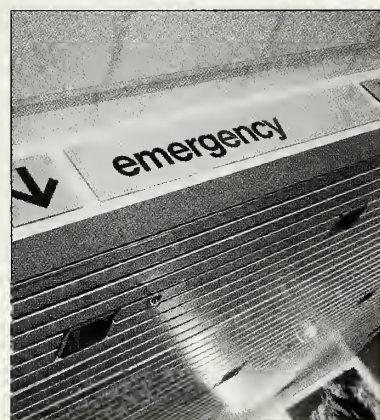
#### 354 People + Events

#### 357 Arkansas Retreats

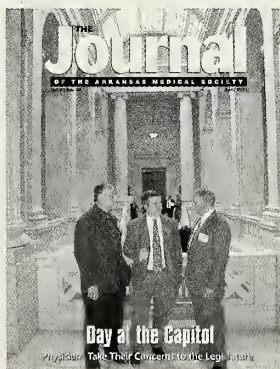
#### 358 Index to Advertisers



India natives Drs. Parthasarathy Vasudevan and Kanaka Vasudevan say they're happy to be practicing in Helena.— page 338



Studies indicate that higher EMS encounter rates with child-ATV incidents occur in rural Arkansas counties.— page 351



On the Cover: Dr. Robert Floss (from left), a family practice physician in Hampton, Rep. Larry Teague of Nashville and Dr. John Hearnshberger, a cardiovascular surgeon in Little Rock, discuss medical-related bills at the Arkansas Medical Society's "Day at the Capitol."

Cover Photo: Mark Wilson





**ROLEX**

*Official Rolex Jeweler*  
**MARY HEALEY'S**  
 FINE JEWELRY

*Because You Love the Best  
 For Those You Love*

5600 Kavanaugh • Little Rock, AR 72207  
 501-661-1314 • 501-661-9368 Fax  
 Mon-Sat 10 am-5:30 pm

Rolex Oyster Perpetual Yacht-Master 18kt gold chronometer. Rolex Oyster Perpetual Lady Yacht-Master steel and 18kt gold chronometer. Both with Oysterlock bracelet. Pressure-proof to 330 feet. Self-winding. Synthetic sapphire crystal. Graduated, rotatable bezel.

Rolex, Oyster Perpetual, Yacht-Master and Lady Yacht-Master are trademarks.



**SPRING  
BREAK**

**pro travel**  
 "SPECIALISTS FOR PROFESSIONALS"

8201 Ranch Boulevard • Building B • Suite 5 • Little Rock, AR 72212 • 501-868-9959 • 800-713-0037

COMMUNICATIONS COORDINATOR  
 Judy Hicks

EXECUTIVE VICE PRESIDENT  
 Kenneth LaMastus, CAE

ASSISTANT EXECUTIVE VICE PRESIDENT  
 David Wroten

#### EDITORIAL BOARD

Sue Chambers, MD	Pediatrics
Joseph M. Beck, II, MD	Oncology
Lee Abel, MD	Internal Medicine
Samuel Landrum, MD	Surgery
Jerry Kendall, MD	Family Practice
William Ackerman, MD	Anesthesiology

EDITOR EMERITUS  
 Alfred Kahn Jr., MD

ARKANSAS MEDICAL SOCIETY  
 2000-2001 OFFICERS

Gerald A. Stolz, Jr., MD, Russellville  
*President*

Joe Stallings, MD, Jonesboro  
*President-elect*

Paul A. Wallick, MD, Monticello  
*Vice President*

Lloyd G. Langston, MD, Pine Bluff  
*Immediate Past President*

Carlton L. Chambers, III, MD, Harrison/Little Rock  
*Secretary*

Dwight M. Williams, MD, Paragould  
*Treasurer*

Anna Redman, MD, Pine Bluff  
*Speaker, House of Delegates*

Kevin Beavers, MD, Russellville  
*Vice Speaker, House of Delegates*

Joseph M. Beck, II, MD, Little Rock  
*Chairman of the Council*

Established 1890. Owned and edited by the Arkansas Medical Society and published under the direction of the Council.

**Advertising Information:** Contact Stephanie Hopkins, P.O. Box 3686, Little Rock, AR 72203, (501) 372-2816.

**Postmaster:** Send address changes to: *The Journal of the Arkansas Medical Society*, P.O. Box 55088, Little Rock, Arkansas 72215-5088.

**Subscription rate:** \$30.00 annually for domestic; \$40.00, foreign. Single issue \$3.00.

*The Journal of the Arkansas Medical Society* (ISSN 0004-1858) is published monthly by the Arkansas Medical Society, #10 Corporate Hill Drive, Suite 300, Little Rock, Arkansas 72205. Printed by The Ovid Bell Press, Inc., Fulton, Missouri 65251. Periodicals postage is paid at Little Rock, Arkansas, and at additional mailing offices.

Articles and advertisements published in *The Journal* are for the interest of its readers and do not represent the official position or endorsement of *The Journal* or the Arkansas Medical Society. *The Journal* reserves the right to make the final decision on all content and advertisements.

Copyright 2001 by the Arkansas Medical Society.





# The Gospel According to 'Calvin and Hobbes'\*

LEE ABEL, MD

If you can remember being a child, or if you have a child (especially a son), then you would probably enjoy Bill Watterson's comic strip "Calvin and Hobbes." Though Mr. Watterson has retired, collections of the comic strip are available as paperback books. For several years, I have kept a couple of "Calvin and Hobbes" anthologies in my exam rooms. I find it a great pleasure to walk into the exam room and find my patient grinning from ear to ear or even laughing out loud at some of Calvin's antics or Hobbes' wit. I feel hopeful that even if nothing else happens in the exam room that day, perhaps the patient's visit will have been therapeutic.

"Laughter is the best medicine" is a popular aphorism. Humor has long been thought to promote health. The Bible says, "A merry heart doeth good like a medicine" (Proverbs 17:22). Humor can be used inappropriately or in a hurtful manner, but we have all experienced its beneficial effects. It can make disappointment and frustration bearable, and add fun to the mundane. It's a great stress reducer and can increase optimism. It can heal wounds that scalpels can't touch and cause regression of even advanced hardening of the attitude.

One of my partners loves to laugh. During the workday, I can sometimes get pretty grim. I'm trying to think hard, or trying hard to think. I'm trying to do the right thing and worried about doing the wrong thing. I'm trying to remember everything I should, and wondering if I'm forgetting something. And then I hear my partner's huge laugh come rolling down the hall. At least on one occasion years ago, I actually thought, "What the hell is so funny?" Now I try to use his laugh as a reminder that often I really could lighten up a bit. The sound of his laughter and the thought of him leaning back in his chair and having a good laugh with a patient makes me smile.

I learned in medical school and residency that pleasure was obtained in medical practice solely from "doing a good job," which involved making the right diagnosis and giving the right medication. My partner taught me it's possible to derive pleasure from just the relationship with the patient. Maybe most doctors figured this out sooner than I did, but being able to laugh with my patients is something I feel thankful for.

Perhaps my experience is not so unusual. A funny thing happens to most people as they pass from childhood to adulthood. They laugh less. Perhaps the humor deficit that arrives with the responsibilities of adulthood is a special challenge for doctors. How do we deal with frightening and serious problems without becoming always serious? How do we deal with events of great gravity without becoming too grave? How do we deal with issues of great importance without succumbing to feelings of self-importance?

I've been impressed that the Dalai Lama seems very happy and has a ready laugh, yet also seems to have a deep awareness of, and empathy for, the suffering of other people. I have also been intrigued by Jesus' teaching that to enter the kingdom of heaven we must become like little children. Perhaps part of what Jesus meant was that it is possible for even us adults to experience life with a childlike sense of awe, wonder and joy. Digging for "buried treasure," Calvin finds "a few dirty rocks, a weird root and some disgusting grubs" and then enthusiastically proclaims to Hobbes, "there's treasure everywhere!"

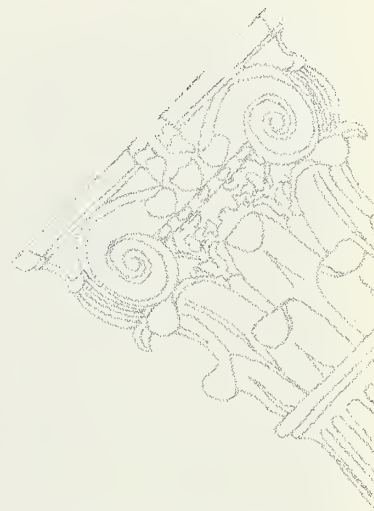
Maybe laughter is not the best medicine, but it's a very good one. The price is right. No insurance company (yet) disallows it or requires prior authorization. Perhaps a lawyer would advise that I add a disclaimer noting that laughter may have side-effects (laughing so hard it hurts) and may be infectious. Of course, lawyers aren't especially known for their sense of humor. Fortunately, a sense of humor can be cultivated. So if you know any good jokes, please send them in. I'm really serious about trying to laugh more. ■

\*Charles Schultz, the creator of the "Peanuts" comic strip, died last year. One of his books was titled "The Gospel According to Peanuts."

## ARCHITECTURE

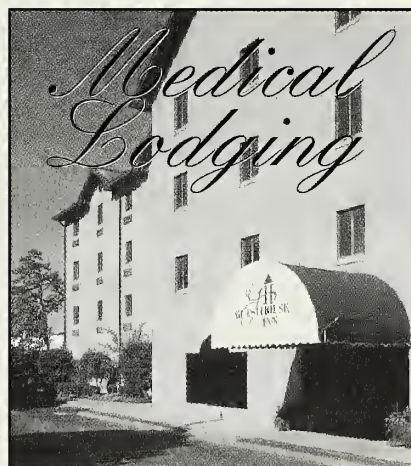
FOR YOUR MEDICAL NEEDS

1 800 764 ASTI



**William Henry Asti, AIA**

architects, economists, development consultants



*Close proximity  
to all Little Rock hospitals*

Serving Little Rock Visitors

- Medical stays
- Business travel
- Leisure travel

*"Guesthouse Inn is your perfect home  
away from home while in Little Rock"*

**GH**  
**GUESTHOUSE**  
Inns • Hotels • Suites

301 S. UNIVERSITY AVE. LITTLE ROCK  
501-664-6800



# YOU CAN TELL A LOT ABOUT YOUR NEIGHBORS BY WHAT THEY DRIVE.



With amenities like a championship golf course and country club, Chenal Valley provides a very livable environment for the most discriminating tastes. To learn more, call Chenal Properties at 501/821-5555.

7 Chenal Club Boulevard • Little Rock, Arkansas 72223  
501-821-5555 • [www.chenal.com](http://www.chenal.com) • e-mail: [chenal@chenal.com](mailto:chenal@chenal.com)

**CHENAL**  
PROPERTIES  
 A DELTIC  
DEVELOPMENT





## Progress on the Long-Range Plan

By CARLTON L. CHAMBERS III, MD

**T**he long-range planning process for the Arkansas Medical Society is alive and well. The three committees — Governance, Communication and Membership — are busy with efforts to provide renewed interest and enthusiasm in our society.

Our effort to respond to the changing professional and economic environment faced by our young physicians is being balanced with maintaining what has been good about our organization.

If you were at the last annual meeting, you were apprised of the need to make some significant changes in how the AMS functions and communicates with its members. Those of you who attended and participated so enthusiastically in the early fact-finding planning meetings enumerated these needs.

As you will recall, one of the greatest obstacles to achieving our goals as an advocacy organization is effective communication. This was made astonishingly clear when a survey of long-range planning volunteers proved that most of them were unaware of many of the activities and efforts of our Arkansas Medical Society.

While the house of medicine is increasingly influenced by the participation of physicians in managed-care entities, PHOs, IPAs and other organizations, we must never forget that we are the house of medicine for all practitioners. The precept that has governed our lives and actions for centuries is the ethical obligation to put our patients first.

As the one organization that can and must speak for the needs of our patients, the Arkansas Medical Society must involve all physicians who are like-minded in that drive to put the patient first.

Any ideas you have about any of these areas should be communicated to the committee chairpersons right away. Specifically, we're looking for ideas on how can we recruit physicians who are not AMS members, how we can ensure that all members' needs and concerns are being met, and most important, how the AMS can more effectively communicate with the membership.

The committee chairs are as follows:

Membership: Dr. P. Vasudevan (870) 338-6749

Communication: Dr. Linda McGhee (501) 521-8260

Governance: Dr. Dwight Williams (870) 239-8504

At the annual meeting May 3-5, we will be reviewing the actions of the committees' work to date. We will be proposing several changes that will be important to all of our members and potential members. This is your opportunity to participate and involve yourself in the process. I urge you to make every effort to attend this meeting in Hot Springs. ■

*Dr. Chambers is the secretary of the AMS, chair of the long-range planning committee and an otolaryngologist in Little Rock.*

DO YOU SUFFER  
FROM TRANSCRIPTION  
OVERLOAD?

## HEALTH DATA SERVICES

*a medical information  
management company*

An independent medical transcription company providing services to small practices, large clinics, and hospital overflow throughout Arkansas.

Phone: (501) 327-7077

Fax: (501) 327-8588

Email: hdsllc@cyberback.com

Looking for  
a temporary  
place to call  
home?

- Fully equipped kitchen
- Non-smoking and handicapped suites
- Outdoor swimming pool, SportCourt and fitness room
- Pets are welcome



Room to relax,  
room to work,  
room to breathe.

1401 Schackelford Rd. • 501-312-0200  
Reservations: 1-800-331-3131



Two of the best financial planners in the nation are in Arkansas.

They can be found at The Arkansas Financial Group.

**CINDY CONGER**  
MBA, CPA/PFS, CFP

**RICK ADKINS**  
MBA, CFP, ChFC



Since 1985, we've been helping busy people make smart financial decisions. So next time you're looking for objective answers to life's crucial financial decisions, call The Arkansas Financial Group. You'll be in great company.

Here's what the editors of *Worth* and *Medical Economics* had to say:

*"The Best 150 Financial Advisers for Doctors, 8/00"*

*"The Best 250 Financial Advisers, 9/99"*

*"The Best 300 Financial Advisers, 9/98"*

*"The Best 250 Financial Advisers, 10/97"*

*"The 120 Best Financial Advisers for Doctors, 7/27/98"*

*"Fee-only, objective, customized, comprehensive, affordable advice"*

**The Arkansas  
Financial Group, Inc.  
376-9051**

PHOTO: KELLY QUINN/TERRITORIAL RESTORATION

## Collect Bad Debt

- Cheaper
- Faster
- In compliance with the Law



If you've always used a collection agency... WHY?

Cut out the collection agency by retaining the Maggio Law Firm.

Save time. Save money.  
Be in compliance with the law.

Have you always used a collection agency because "that's the way you've always done it?"

*Try a new way... tip the scales in your favor, call today.*

# MAGGIO LAW FIRM

*your collection law firm*

Offices in Conway and Searcy • 1-800-600-3201  
[www.ebaddebt.com](http://www.ebaddebt.com)



# Day at the Capitol

Arkansas  
Physicians  
Spend Time  
Lobbying Local  
Legislators

Photo Mark Nilson

By Shelby Brewer

★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★

**D**octors traveled many miles, taking time out of their busy schedules, to attend the AMS' annual "Day at the Capitol" program.

The activities began with registration at 11:30 a.m., followed by a catered lunch at noon at the Arkansas Education Association Building. After lunch, Zeno gave the guests an overview of more than 50 health-related bills being debated during the 83rd General Assembly. Then the guests headed to the Capitol to visit with their legislators and to watch the Legislature in action.

Some of the bills on the AMS' radar include three public health bills pertaining to cigarette smoking. Zeno urged Society members to ask their legislators to oppose these bills.

The first of the bills, House Bill 1250, introduced by Rep. Dean Elliot, R-Maumelle, prohibits the Arkansas Department of Health from regulating or prohibiting smoking in restaurants with a seating capacity of less than 25, or in any eating establishment where required modifications (air filtration systems, etc.) would not be readily achievable.

Zeno said the bill is bad for three obvious reasons: 1.) It removes the authority to regulate smoking from the state Department of Health, the very entity that is in charge of protecting public health. 2.) It exempts small eating establishments, which are generally in confined spaces where patrons and employees are the most susceptible to the effects of secondhand smoke. 3.) It gives every eating establishment, regardless of size, an excuse to ignore any safe air modifications required by the Health Department by simply saying that the modifications are not readily available.

To emphasize the dangers of secondhand

★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★

*Shedding their white coats for a day, doctors across the state gathered together for a common purpose — to voice their views. More than 100 physicians, spouses, medical students and clinic managers united at the state Capitol Jan. 31 to meet with legislators — a process that is essential in protecting the future of medicine, said Lynn Zeno, director of governmental affairs for the Arkansas Medical Society.*

★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★



smoke, Zeno read a letter from an oncologist about a woman who worked in a restaurant where smoking was allowed:

"A 58-year-old white female worked for the past 25 years in a small-town cafe. She reports that nearly everyone at the cafe smokes, and she serves meals there six days a week. In July, she was noted to have multiple pulmonary nodules and was found to have a non-small cell carcinoma of the lung. She has never smoked and does not live in a house with smokers. Her only exposure is in her workplace. She's received six months of chemotherapy with some stabilization of disease. It's my opinion that this cancer was induced by secondhand smoke."

Dr. Douglas Snyder, an anesthesiologist at the University of Arkansas for Medical Sciences, agreed secondhand smoke is a threat to public health and that this bill is indeed a step backward.

"I would like to see smoking prohibited in public places, especially restaurants, and I certainly agree that people shouldn't have to walk through smoke to access a hospital," Snyder said. "The smoking should be limited to areas that are physically removed from the entrances to the hospital."

Smoking in hospital entranceways was also a topic at the lunch program, and many doctors expressed their disapproval of it. But doctors also acknowledged that a total ban of smoking in hospitals might cause the hospitals to lose several good nurses who smoke.

Dr. Carlton Chambers, an otolaryngologist for UAMS and secretary of the AMS, was also against the passage of this bill.

"That should be our most important activity right now — making sure this bill doesn't get passed," Dr. Chambers said, "because it will reduce the effectiveness of the public Health Department's action in curtailing smoking. Basically, we just need to let the public Health Department do what it does — regulate the healthy environment of the community."



Lynn Zeno

*Studies  
show that  
smoking  
kills more  
Americans  
than  
alcohol,  
AIDS, car  
crashes,  
illegal  
drugs,  
murders  
and  
suicides  
combined.*

The second smoking-related bill, House Bill 1429, introduced by Rep. Sandra Rodgers, D-Hope, would repeal Arkansas Code 22-3-220, which prohibits smoking in the state Capitol.

Zeno said that in a recent special session, legislators were given statistics from the U.S. Centers for Disease Control and Prevention on smoking. Studies show that smoking kills more Americans than alcohol, AIDS, car crashes, illegal drugs, murders and suicides combined.

Other statistics mentioned were that 5,200 Arkansans die each year from smoking and that \$600 million in annual health care expenditures in Arkansas are directly related to tobacco use.

Zeno said this bill should be opposed to protect the nonsmoking legislators and other members of the public from the damages of secondhand smoke.

"And Arkansas legislators should serve as role models for all citizens in the fight against tobacco use, especially the thousands of youngsters who tour the state Capitol," he said.

The third bill, House Bill 1430, also introduced by Rodgers, amends Arkansas Code 6-21-609, which

prohibits smoking or the use of tobacco products in or on any property owned or leased by public school districts.

The obvious reason this bill should be opposed, Zeno said, is that the current prohibition on tobacco use on public school property not only helps protect our children, but also ensures that faculty and other school personnel serve as role models for the students.

Statistics show that 11,000 Arkansas children under age 18 become new daily smokers each year and that Arkansas ranks third in the nation in the number of children who smoke, Zeno said.

In addition to the smoking legislation, the Society is also closely monitoring legislation relating to tort reform and managed care during the session.

#### **Making Opinions Heard**

Overall, Zeno said the "Day at the Capitol" event, which began in 1989, was a success. AMS staff was especially pleased with the turnout, which was larger than the Society staff expected.

"I'm always amazed at how many physicians — who have in the past been reluctant to contact their legislators — realize how easy it is to talk to legislators after they see how the legislative process works."

Several legislators, in turn, said they were impressed at how well large associations, such as the Arkansas Medical Society, communicate their political interests.

"Without question, there is power in numbers," said Sen. Jon Fitch, D-Hindsville, "and the associations get a lot more credibility because they are representing a larger group and a more diverse flow of ideas."

Fitch said although legislators may not always agree with the views of associations, they do put a lot of confidence in their opinions.

Rep. Marvin Steele, D-West Memphis, agreed that associations and grassroots communication are helpful to legislators. "I use them to



get a lot of information, and I have found them to be a source of good, reliable information," he said. Steele said the Medical Society, specifically, has been helpful to him since he's the vice chair of the Public Health, Welfare and Labor committee. "Anytime I need to know something about an issue, they've gotten me all the information I've needed to know, whether it was in regards to an issue they're for or against."

Steele offered his thoughts on House Bill 1250, which prohibits the state Health Department from regulating or prohibiting smoking in restaurants with certain seating or air filtration system limitations.

"I am in favor of restaurants providing a nonsmoking area," he said, "but I don't know if I'm willing to make restaurants completely smoke free. I think restaurants should provide areas for both smokers and nonsmokers, and I think restaurants should have the choice."

## Keeping Tabs

Although the three smoking bills are important issues for the AMS, there are many others the Society tracks and alerts members about.

From the beginning of the legislative session, the Society has sent weekly bulletins to its members, highlighting the hot issues for that week.

Zeno said that as of Feb. 1, 66 of the 896 bills introduced were medical-related. Generally, he said, more than 200 medical-related bills are introduced by the end of a session.

At the Society's 2000 Fall Meeting in October, Michael E. Dunn, president of Michael E. Dunn and Associates Inc., a public affairs consulting company in Arlington, Va., reminded physicians that issues that affect them are often determined by legislators who have no background in health care and that physicians are the most qualified to convey their needs and the needs of their patients to lawmakers.

Zeno agreed with Dunn's comments. "The Medical Society and its governmental affairs team have been very successful in monitoring legislation and representing the concerns of Arkansas physicians," Zeno said. "But we can't overestimate how important it is for our local physicians to communicate with their local legislators."

Wrapping up the day's activities, the Society held an evening reception at the Arkansas Arts Center to honor the members of the Legislature. A crowd of more

than 300, including nearly every legislator from every district, attended the reception, which Zeno said was an excellent turnout.

Among some of the legislators attending were Senate President Pro Tem Mike Beebe of Searcy and House Speaker Shane Broadway of Bryant.

The purpose of the "Day at the Capitol," Zeno said, was to give doctors and others a chance to raise questions and talk to legislators about issues that could affect doctors and, more important, their patients. After talking with doctors and legislators, that goal seemed to be accomplished.

At the end of the day, Drs. Wayne Brooks and Mitch Singleton reflected upon the benefits of getting involved in the legislative process.

Dr. Brooks, a physical medicine and rehabilitation doctor at Northwest Medical Center in Springdale and past president of the Washington County Medical Society, said as a whole, physicians are usually poor at making their voice heard.

"Even though we have good lobbyists, as individuals, we don't do as good a job, so I think it's important that we show up and let people know we are interested and that we are looking to see what our representatives are doing," he said.

Dr. Singleton, a Fayetteville ophthalmologist and current president of the Washington County Medical Society, advises doctors to take the first step in becoming involved in the legislative process — being an active member of the AMS.

"You've got to stand up and be counted," he said. "You've got to get involved. We all gripe about what all the insurance companies, HMOs and the government regulators are doing to us, but the only alternative we have is for the AMS to speak for us. We're lucky to have Lynn Zeno and the rest of the staff to do that. With every issue we have, they've always been very responsive. They do a good job of representing us." ■



*Lynn Zeno speaks about medical-related bills at the afternoon luncheon.*



# Meet Our Members

## Drs. P. and Kanaka Vasudevan

By SHELBY BREWER

**F**or husband-and-wife team Drs. Parthasarathy Vasudevan, a urologist, and Kanaka Vasudevan, an anesthesiologist, the string of events that led them from India to Helena, Ark., has made all the difference in their lives.

Dr. P., 62, who was born in Malaysia and schooled in Madras, India, prefers that his patients call him by his first initial since his name is difficult to pronounce. He said it was his wife's brother who sparked his interest in moving to the United States.

"Her [Dr. Kanaka] brother was already here, and he was always telling me about all the good things in America," Dr. P. said. "And she was really keen on the idea, so we decided we'd move."

In 1973, the Vasudevans moved to New York City, where Dr. P. completed his first year as a surgical resident at Jewish Memorial Hospital. Soon afterward, the couple moved to Boston, where they had two sons — Barath, now 26, and Deepu, 24. Besides taking care of two baby boys, the couple also completed their residencies and fellowships — Dr. P. in urology and Dr. Kanaka in anesthesiology — while living in Boston.

Ending up in Helena was a blessing, the couple say.

After seeing an ad in the *Journal of the American Medical Association* searching for a urologist to move to Helena, Dr. P. moved his family to the small town, and immediately liked what he saw.

"The people were really nice to me. They picked me up at the airport, showed me around, and we had all kinds of funny questions we

asked each other," he said. "After 23 years of living here, I have no regrets," he said.

Today, Drs. P. and Kanaka are settled in Helena and have a private practice. As a couple, they have several things in common. Both are from India, both are doctors, and both said they were influenced to go into their specific fields by fellow Indians.

After attending medical schools in both India and America, Dr. P. said he had noticed one major difference between them — testing systems.

"Passing an examination is tough [in India] because we follow the British system. We don't have these four-answer, multiple-choice questions. Everything we answered had to be in essay form."

He said American medical schools are better, however, at teaching students the practical aspects of medicine rather than just the theory behind it.

But one thing that stays the same no matter what country the couple are in is their dedication to their marriage. And perhaps just as interesting as their voyage to Arkansas is the story behind their marriage.

"In India, traditionally, we believe in arranged marriages," Dr. P. explained. "Their family would contact our family, and then the parents would decide if there's a suitable match or not. They'd compare horoscopes and whatnot, and then we'd get to meet each other."

He said that in their case, it was different because her brother was a good friend of his and he already knew her.

"And since she was in medical school in India and I had already done mine, we decided we could match." The couple were married in 1970.

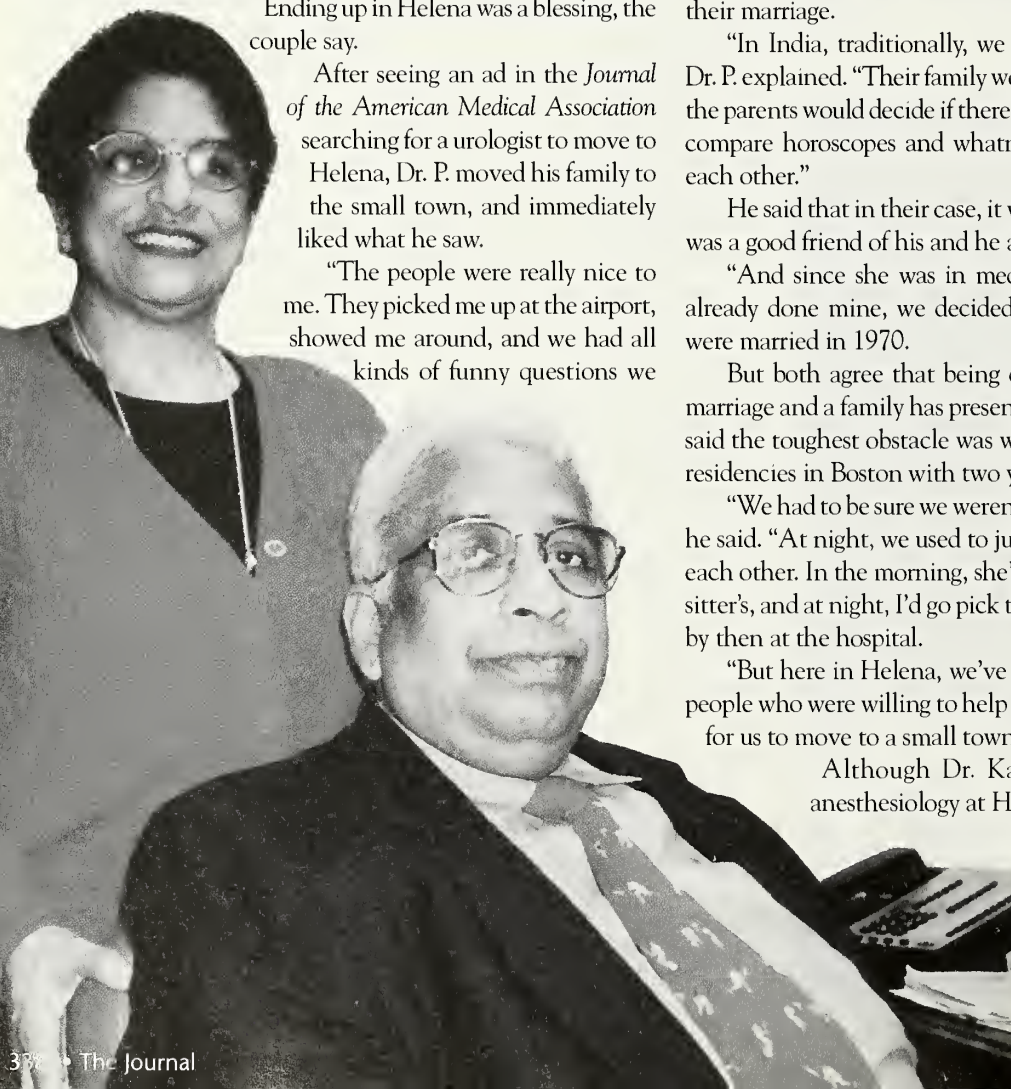
But both agree that being doctors and trying to balance a marriage and a family has presented its share of difficulties. Dr. P. said the toughest obstacle was when they were both doing their residencies in Boston with two young boys.

"We had to be sure we weren't both on call at the same time," he said. "At night, we used to just exchange kids without seeing each other. In the morning, she'd leave the children at the baby sitter's, and at night, I'd go pick them up because she'd be on call by then at the hospital."

"But here in Helena, we've had some wonderful, wonderful people who were willing to help us out. It has been a real blessing for us to move to a small town."

Although Dr. Kanaka is now the director of anesthesiology at Helena Regional Medical Center,

*Although their native India is far away, the Vasudevans have made a home in Helena.*





her earlier days as an anesthesiologist weren't so easy.

When she started treating patients at the hospital in the '70s, she debated with other physicians on staff about the use of cyclopropane, a highly flammable gas that was once used as an anesthetic to put pregnant mothers to sleep before delivery but is now banned.

If it weren't for the encouragement of Dr. Richard Clark, a professor at the University of Arkansas for Medical Sciences in Little Rock, Dr. Kanaka said she would have quit working at the hospital. Dr. Clark, who is now retired, sent a letter to the chief of staff at the hospital, explaining that cyclopropane is not in use anymore and that the gas, along with the canister, is even used as an antique to show students.

After that, Dr. Kanaka said the doctors apologized, but they couldn't offer her a job. "I asked for \$30,000 and they couldn't pay that. But that was a good thing for me because I went into my own practice, and it gave me a lot of confidence," she said.

Dr. Kanaka said upgrading the department of anesthesia to what it is today is one of her greatest achievements. "Before, they didn't have good equipment and they didn't have the drugs we wanted. Today, it has much higher standards and quality."

Dr. P. has had his own hurdles to jump as well, but the biggest challenge he faces as a doctor in the Delta, he said, is figuring out how to take care of the indigent population.

He said that he takes care of the indigent in his office at no charge whenever possible. But when these patients need attention at the hospital, he said, it's more difficult.

He estimated that 10 percent of the Helena area's population is indigent.

"We have a good number of them in the Delta, and most doctors here have to take care of them."

Dr. P. said he is very happy that they moved to a small town, mainly because it has allowed him to become involved in the community, which is what he loves the most.

He is the president and founding member of the Phillips County Community Foundation and Delta Health Alliance, chairman of the membership committee of the Helena Chamber of Commerce, and assistant district governor of the Rotary Club. He's also very involved with the Arkansas Medical Society, serving as the membership committee chairman. When he's not busy volunteering, Dr. P. likes to garden, swim, listen to classical Indian music and watch C-SPAN.

Dr. Kanaka is also involved in the Medical Society as well as the Arkansas Society of Anesthesiologists. In her spare time, she likes to listen to music, surf the Internet and experiment with digital photography.

The Vasudevans joined the Arkansas Medical Society in 1978, and both agreed that it has been a blessing.

"Any time I have any problems, all I have to do is pick up the phone and call them, and they'll help us out," Dr. P. said. "Without the society, it seems like it would be very difficult to survive." ■



## The E 320.

It makes a convincing argument for "rational exuberance."

Distinctive design. Soft leather upholstery. A total of 8 air bags. And a powerful 221-horsepower V-6 engine that can take you from 0-60 in 7.1 seconds.\* Among luxury cars, the E 320 has been a role model for performance, style, safety, value-and, of course, exuberance. **The E-Class**



**Mercedes-Benz**

## Riverside Motors, Inc.

1403 Rebsamen Park Road, Little Rock, AR (501) 666-9457 • 1-800-457-6226 • [www.riversidemotors.com](http://www.riversidemotors.com)

\*Stated rates of acceleration are based on manufacturer's track results and may vary depending on model, environmental and road surface conditions, driving style, elevation, and vehicle load. Please always drive safely. To learn more, call 1-800-FOR-MERCEDES or visit [www.MBUSA.com](http://www.MBUSA.com). WARNING: THE FORCES OF A DEPLOYING AIR BAG CAN CAUSE SERIOUS OR FATAL INJURY TO A CHILD UNDER AGE 13. THE SAFEST SEATING POSITION FOR YOUR CHILD IS IN THE REAR SEAT, BELTED INTO AN APPROPRIATE, PROPERLY INSTALLED CHILD SEAT, OR CORRECTLY WEARING A SEAT BELT IF TOO LARGE FOR A CHILD SEAT. A CHILD UNDER 13 SHOULD NOT USE THE FRONT SEAT UNLESS THE CHILD IS BELTED INTO AN APPROPRIATE, PROPERLY INSTALLED BABY/SMART COMPATIBLE CHILD SEAT. A CHILD UNDER 13 WHO IS TOO LARGE FOR A CHILD SEAT SHOULD IN OF USE THE FRONT SEAT. SEE OWNER'S MANUAL FOR ADDITIONAL WARNINGS AND INFORMATION ON AIR BAGS, SEAT BELTS AND CHILD SEATS. BabySmart is a trademark of Siemens Automotive Company. ©2000 Authorized Mercedes-Benz Retailers





# The Same Lesson Again and Again

J. KELLEY AVERY, MD

An excision biopsy showed adenocarcinoma, with normal nodes. Because of the clinical findings and the tissue analysis of the tumor, a modified radical mastectomy was done, and at least two of the removed nodes were positive for tumor.

## Case Report

A 37-year-old woman, gravida 2, para 2, with one living child had a regular examination every year at her local health department (HD). She was a moderate smoker and used birth-control pills (BCPs) for contraception.

Five years before her death, she had a routine examination at the HD, where the examining nurse felt some "nodular thickening" in the left breast. The nurse strongly recommended a mammogram and cautioned the patient about the risks of taking BCPs and smoking. The patient was asked to consider other contraceptive methods and was urged to stop smoking, but she stated that the pill was the only method she was willing to use at that time, and was given a supply of them.

Five weeks later, the mammogram was done, and the mammographer reported fibronodular tissue in both breasts. There were calcifications in the left breast that appeared to be benign, but there was no indication of malignancy. No return date was suggested, and no repeat mammogram was advised.

The report of the mammogram was sent to the HD, where the physician saw the report and documented that he wished to see and examine the patient in two weeks.

On examination, the HD physician considered that a malignancy could not be ruled out and documented a "possible lump, left breast." The nurse called the patient and left a message on the answering machine for the patient to call, but she did not.

Three months later, the patient returned to the HD for her routine annual examination by the nurse practitioner and was scheduled to return to see the physician.

Following this visit, the physician made an appointment for the patient to see a general surgeon. He stated in his referral note, "She has a small lump just above the nipple and the mammogram shows a benign-appearing calcification in the left breast, but I felt that she ought to have it checked." The HD physician

drew a diagram of the mass he felt and made it a part of the consultation request. She received only one month of BCPs, and was told that she would have to see the consultant before she got any more.

When she did not keep the appointment, it was rescheduled, and again she was informed that no further services would be given by the HD until she saw the surgeon and he evaluated her breast.

Nine months after the initial report, the patient was evaluated by the general surgeon, who reported that neither his examination nor the mammogram found any evidence of malignancy.

"I am not planning to see her again unless she develops future problems," he wrote. "I recommend that she have a follow-up mammogram in two years." The HD physician recorded that the consultant saw no need for biopsy at that time.

About a year later, the patient reported to the HD for her usual examination with the statement that she had a white discharge from both breasts. There were two lumps said to be at the 10 and 11 o'clock positions. She said that the lumps seemed bigger but that she was being followed by the consultant and was supposed to see him "next summer."

She was told that no further BCPs could be given, since she was a smoker and needed a follow-up mammogram. The examination was done with the finding of a large 5-by-4-cm irregular lesion, which the mammographer strongly suggested be biopsied.

An excision biopsy showed adenocarcinoma, with normal nodes. Because of the clinical findings and the tissue analysis of the tumor, a modified radical mastectomy was done, and at least two of the removed nodes were positive for tumor. The patient chose a different surgeon from the first consultant.

Her recovery from surgery was uneventful. The final diagnosis was a Stage 2 carcinoma of

the breast with two of nine removed nodes positive for cancer. Chemotherapy was begun. Scanning technology was used to determine the absence of brain, bone, or liver/spleen metastasis.

She was followed closely by the oncologist, and chemotherapy ended about three years after the initial mammogram. At that time she appeared to be cancer-free and was excited about her plans to pursue a nursing education.

Sixteen months later, she was admitted to the hospital because of a very heavy menstrual period. She had lost weight and was obviously anemic. A thorough workup revealed metastatic disease involving the chest (pleura with effusion), bone, and soft tissues of the abdomen. She was in renal failure due to bilateral ureteral obstruction, for which stents were placed.


The kidney problem cleared, and the oncologist continued to follow this patient closely. She was aggressively treated with chemotherapy, required repeated hospitalizations for complications of her disease and her treatment, and died about seven years after the first suspicious mammogram.

A lawsuit was filed two years before her death, charging all concerned with her treatment with negligence in the failure to diagnose and treat cancer of the breast in a timely fashion. Early in the litigation, the HD physician and the hospital were dismissed from the case. The patient died while the case was being developed for trial.

### Loss Prevention Comments

It is apparent that this patient could be seen as contributing to her own problems. She was noncompliant with instructions to get the mammogram in the first place. She was slow to get to the first surgical consultant for the first examination, and she did not return at all after the HD doctor suggested that he should re-evaluate her. She continued to insist on oral contraception after having been told time and time again to stop smoking because the combination of BCPs and smoking was dangerous. She was a noncompliant patient.


In evaluating a case of this sort, it must be remembered that the arena of




*Introducing the*

## DIAMOND STAR

**Fast: 147 Knots / 169 MPH**  
**Affordable: Ownership from 25% to 100%**  
**And Fun!!!**

 **CENTRAL**  
FLYING SERVICE


Call Cheri McKelvey  
501-975-9321

 **SKYSHARE**<sup>SM</sup>

# 3

## Three New Ways To Make Your Referrals To UAMS Easier

- 1. Log on to <http://physicianlink.uams.edu>.
- 2. Use the new exclusive referring physician toll free appointment line, 1-866-UAMSDOC (826-7362).
- 3. Stop by our booth at the Arkansas Medical Society's Annual Meeting and learn more.

  
 Where Knowledge Creates Better Medicine

Physician Referral Office • 4301 West Markham, Slat 727  
 Little Rock, AR 72205 • 501/686-8206



# The strength of CARTI.



## 25 years.

The strength of CARTI is in 25 years of providing the very latest in radiation therapy to the cancer patients of Arkansas. From the 3D imaging and treatment equipment installed in every CARTI facility to our seventh center, just opened on the campus of UAMS, we provide the finest in radiation therapy close to home for our patients and yours. Now, building on our national leadership in radiation seed implants for prostate cancer, CARTI introduces vascular brachytherapy, radiation implants that change the way angioplasty is delivered. Our 25 years include milestones like achieving JCAHO's first accreditation of a freestanding radiation therapy center, and earning the Arkansas Governor's Quality Award. But our highest honor remains serving you and your patients. We continue to seek the latest in proven treatment technology, because the strength of CARTI is in 25 years of caring professionals providing professional care.

*For more information, or to refer a patient,  
call 501/664-8573 or 800/482-8561.*



**Winning through radiation therapy.**

*Little Rock: Baptist • St. Vincent • UAMS  
Conway • Mountain Home • North Little Rock • Searcy*

[www.carti.com](http://www.carti.com)

medical malpractice is not a scientific arena. The issues embodied in the case must be evaluated from a lay jury's perspective. The last thing to which such a jury would be sympathetic would be for the defense attorney to try to assess liability to this dead woman.

The surgical consultant saw this patient nine months after the suspicious mammogram. Experts believe that he should have repeated the test. Although the consultant did not feel the mass, other examiners, both the nurse and the HD physician, had felt it, and since the evaluation of a small lesion in a nodular breast is difficult, the mammogram should have been repeated.

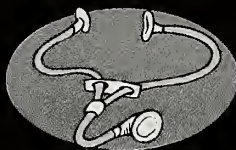
Experts further agree that in all probability, the 1-cm lesion had not yet spread. The initial mammogram that described the nodular breast and the "benign-appearing calcification in the left breast" also stated that "neoplasm cannot be ruled out." In this situation, the mammogram should have been repeated, and if the findings were still equivocal, a biopsy was indicated at that time.

As the preparation for trial proceeded, the plaintiff took the deposition of the patient, who was desperately ill. Since it was also thought that "a day in the life of" videotape was planned for the trial, the defendant physician requested that the case be settled. A negotiated settlement of a moderate six-figure amount, which included more in treatment costs than in paid loss, was achieved.

Again and again we have described cases of this type that have consistently strongly indicated the necessity of a breast biopsy when, after mammography and careful physical examination, there remains even a suspicion of neoplasm. ■

*Reprinted from an October 1999 issue of Tennessee Medicine. The Case of the Month is taken from actual Tennessee closed claims. An attempt is made to fictionalize the material in order to make it less easy to identify. If you recognize your own case, please be assured that it is presented solely for the purpose of emphasizing the issues presented.*

# CARDIOLOGY



## Thoracic Aortic Aneurysm Revisited

VENKATARAMA GADDAM, MD — ASEM RIMAWI, MD — JOHN MCKEE, MD  
EDITOR: EUGENE SMITH III, MD

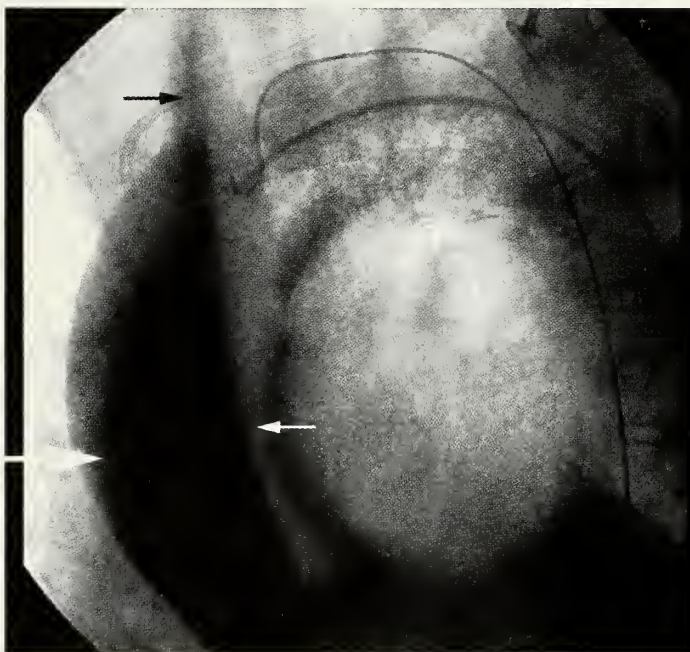
Aortic aneurysm is the 13th most common cause of death in the United States. The incidence of this disease is estimated to be 5.9 cases per 100,000 person-years. Aortic aneurysms are best described as a permanent, localized progressive dilatation of the aorta having a diameter of at least 1.5 times that of the expected normal diameter of a given segment. We describe a case of aortic dissection to highlight the difficulties in diagnosis and management of thoracic aortic aneurysms.

### Case No 1:

An 81-year-old male presented to the emergency department with complaints of chest pressure starting one hour before arrival. He described the pressure to be deep in his chest, almost at the back. His past medical history was significant for colon cancer.

He was noted to have low blood pressure with systolic blood pressure between 80–90 mm Hg and a heart rate of 90/min. He had ST depression on the electrocardiogram in the inferior leads, for which he was diagnosed with unstable angina and treated with aspirin, intravenous heparin, intravenous metoprolol and intravenous morphine for pain control.

Because of the presence of persistent ST depression and chest pressure, the patient was taken to the catheterization laboratory for left heart catheterization. His left coronary arterial system was normal. Due to the inability to engage the right coronary artery, an aortic root injection was performed, which revealed a



**Figure 1:** Aortic root angiogram showing the small true lumen (thin white arrow), large false lumen (blocked white arrow). The false lumen extends into the right innominate artery (black arrow).

Type 1 thoracic aortic aneurysm (TAA) that extended to the abdominal aorta distal to the renal arteries (Figure 1). The patient was immediately rushed to the operating room for repair. He died during surgery due to profound left ventricular dysfunction.

### Case No 2:

A 65-year-old man was admitted for treatment of ventricular tachycardia causing dizziness. He had a bicuspid aortic valve that was replaced in 1993. He was noted to have poststenotic aortic root dilatation of 4 cm. His aneurysm progressed from 6.3 cm to 9 cm within the last 5 years (Figure 2). Though

surgical correction was offered, he preferred a conservative approach toward management of this aneurysm. He agreed for surgery in October 2000 and had aortic root and valve replacement. He was discharged home on the eighth postoperation day.

### Discussion

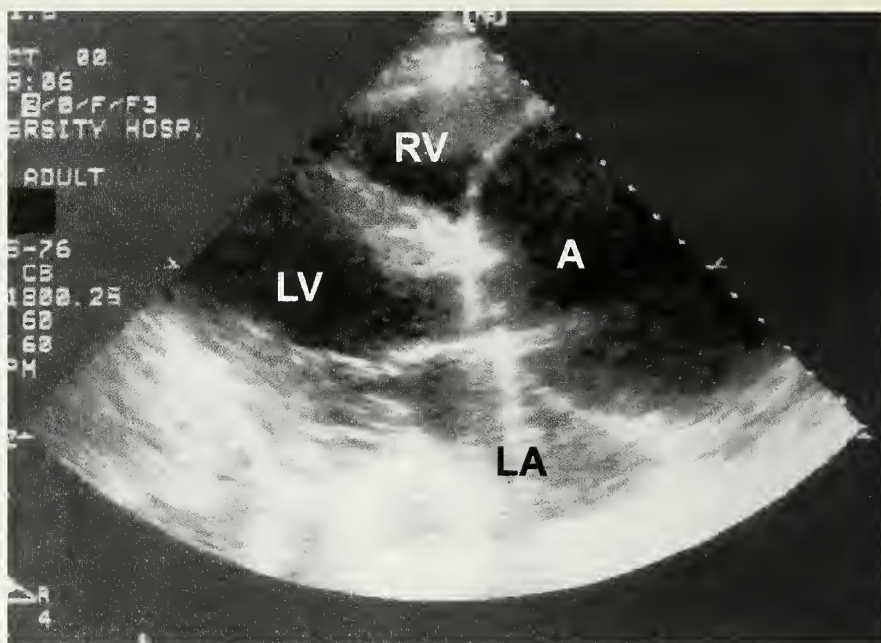
The incidence of this disease is estimated to be 5.9 cases per 100,000 person-years. The mean age at the time of diagnosis ranges between 59 and 69 years, with men predominating over women with a ratio of 2:1 to 4:1. TAAs have a variety of causes, including atherosclerosis, cystic medial degeneration, myxomatous degeneration due to Marfan's syndrome, infection, trauma, poststenotic dilatation and syphilitic aortitis. Forty percent of patients are diagnosed incidentally on routine imaging studies.



Chest pain and pressure are the most common presenting symptoms. It can also cause cough and dyspnea from tracheobronchial obstruction, hoarseness due to pressure on the recurrent laryngeal nerve, dysphagia secondary to esophageal narrowing, or superior vena-caval syndrome. TAA can cause aortic regurgitation, due to aortic root and annular dilatation that leads to congestive heart failure. Narrowing of the coronary ostia by enlarged sinuses of Valsalva can cause ischemia or infarction. The most worrisome consequences are of rupture or dissection of the aneurysm. Rupture into trachea can cause hemoptysis and rupture into the GI tract can produce hematochezia (aorto-esophageal fistula).

Many TAAs are brought to clinical attention by chest X-ray done for other purpose. Angiography is the gold standard with 90% sensitivity and 95% specificity. Transesophageal echocardiography, computerized tomography, or magnetic resonance imaging with gadolinium and angiography are commonly used for accurate characterization of the aneurysm. Ultrasonography, though very useful for AAA (abdominal aortic aneurysm), is not so in case of TAA. Intravascular ultrasonography is an emerging new technology that provides exceptionally high resolution images of the aneurysm.

The natural history of TAA is quite



**Figure 2:** Para-sternal long axis view of echocardiogram showing massive aortic root aneurysm (A), Left ventricle (LV), left atrium (LA), and right ventricle (RV).

diverse, reflecting a broad spectrum of etiologies. Much of the available evidence on growth rates and risk factors derives from studies of AAA. Such risk factors include size, hypertension, smoking, syphilis and arteriosclerosis. Aneurysms are classified based on the position (Figure 3).

### Treatment

All aneurysms are potentially fatal with unpredictable rates of expansion and

rupture. Beta-blockers have been shown to reduce the pulsatile force on the aortic wall, by reducing the blood pressure, thus reducing the size and progression of the aneurysm. Though propranolol has been used in trials, other beta-blockers can be assumed to have the same effect.

In acute dissection, agents with fast onset of action and short half-life should be used, as they stabilize the dissection and prevent rupture. (See Table 1)

### Surgical Management

Most vascular surgeons currently recommend surgery for:

- asymptomatic aneurysms 5 cm or larger
- symptomatic, including Aortic regurgitation, CHF
- acute dissection involving the ascending aorta

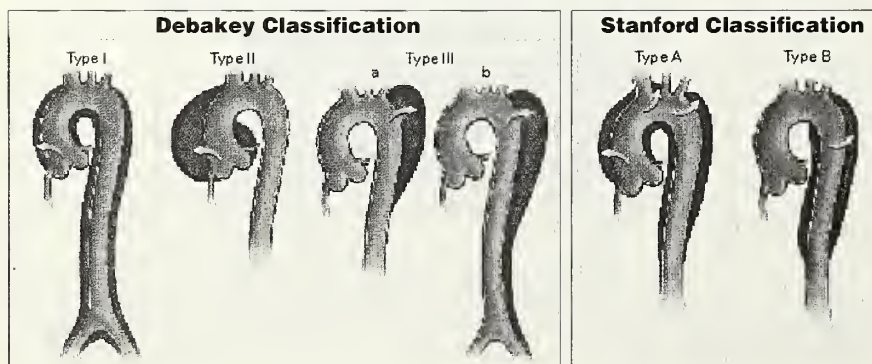
While more aggressive management of smaller aneurysms (4-5 cm) has been recommended by some, others have suggested that asymptomatic, slow-growing aneurysms under 6 cm can be successfully followed by serial CT scans. All decisions are individualized to each patient.

The most common modality of surgical repair is replacement of the ascending aorta and the aortic valve with a composite graft containing a Dacron graft and mechanical valve prosthesis,

### Figure 3

#### The Two Most Widely Used Classifications of Aortic Dissection

The DeBakey classification includes three types. In **type I**, the intimal tear usually originates in the proximal ascending aorta and involves the ascending aorta, the arch and variable lengths of the descending and abdominal aorta. In **type II**, the dissection is confined to the ascending aorta. In **type III**, the dissection may be confined to the descending thoracic aorta (**type IIIa**) or may extend into the abdominal aorta and iliac arteries (**type IIIb**). The dissection may extend proximally to involve the arch and the ascending aorta. The Stanford classification has two types. **Type A** includes all cases in which the ascending aorta is involved by the dissection, with or without involvement of the arch or the descending aorta. **Type B** includes cases in which the descending thoracic aorta is involved, with or without proximal (retrograde) or distal (antero-grade) extension. (Reprinted with permission.)<sup>5</sup>



**Table 1**

<b>Monitoring</b>	Blood pressure Cardiac rhythm Possibly with pulmonary artery catheterization
<b>Beta blockade</b> (should be used even if the blood pressure is normal)	Esmolol IV: 500 mug/kg/min for 1 min, then 50 mug/kg/min for 4 minutes, then maintenance infusion of 10-50 mug/kg/min Labetalol: 20 mg IV over 2 minutes, repeat every 10-20 minutes up to 300 mg Propranolol: 1-2 mg IV every 4-6 hours
<b>Pain control</b>	Preferable IV medications, e.g. morphine, meperidine
<b>Blood-pressure control</b> (Goal is mean blood pressure 60-70 mm Hg)	Sodium nitroprusside—start at 0.3 mg/kg/min IV Alternatives: Intravenous calcium channel blockers / angiotensin converting enzyme inhibitors
<b>Hypotension</b>	Titrate anti-hypertensive management, if not tolerated can use neo-synephrine

with implantation of the coronary arteries in the Dacron graft. Aortic allografts are also used when preserving the native valves is possible.

Mortality depends on the etiology of the aneurysm, but varies between 0% to 6%, with 5-year survival 60%-90% and a 10-year survival of 50% to 70%.

### Conclusion

Due to the potentially fatal compli-

cation, high index of suspicion for aneurysm needs to be maintained when patients present with atypical chest pain. Beta-blockers should be started even if the blood pressure is normal. Diagnosis should be made using any one of the available modalities. Prompt surgery with repair of the dissection can save lives. Asymptomatic aneurysms with size less than 4 cm need close follow up with CT scan every 6 months. ■

Drs. Gaddam, Rimawi and McKee are with the department of cardiology at the University of Arkansas for Medical Sciences. Dr. Smith is with the division of cardiology, UAMS Medical Center and John L. McClellan Memorial Veterans Hospital in Little Rock.

### References:

1. Fuster V. Medical treatment of the aorta. *Cardiol Clin* 1999. 17(4): 697-715, viii
2. Leach SD, Toole AL, et al. Effect of beta-adrenergic blockade on the growth rate of abdominal aortic aneurysms. *Arch Surg* 1988. 123:606-609.
3. Shores, J, Berger K, et al. Progression of aortic dilatation and the benefit of long term beta blockade in Marfan's syndrome. *N Engl J Med* 1994. 330:1335-1341.
4. Coady MA. Natural history, pathogenesis, and etiology of thoracic aortic aneurysms and dissections. *Cardiol Clin* 1999. 17(4): 615-35.
5. Kouchoukos NT, Dougenis D. Surgery of the thoracic aorta. *N Engl J Med* 1997. 336:1876-88.



**continuing  
medical  
education**



Office of Continuing Medical Education...

**Committed to Life-Long Learning**

### 2001 Programs

**Apr. 5-7 Symposium on Critical Care and Emergency Medicine**

Location: Arlington Resort Hotel, Hot Springs, AR

Joint Sponsors: UAMS and Univ. of Tennessee

**Apr. 25 Best Practices in the Continuum of Care**

Location: DoubleTree Hotel, Little Rock, AR

**May 5 W.W. Stead Chest Symposium**

Location: The Austin Hotel, Hot Springs, AR

**May 11 The Diamond Conference**

Location: The Riverfront Hilton Inn, North Little Rock, AR

**May 19 The Diabetes Update 2001**

Location: The Holiday Inn Select, Little Rock, AR

**June 1-3 23rd Annual Family Practice Intensive Review**

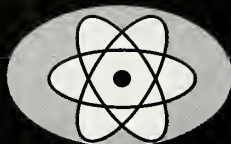
Location: UAMS Education II Building, Little Rock, AR

For additional information,  
call the Office of Continuing Medical Education at (501) 661-7962  
or check out our website, [www.uams.edu/cmefd/cme2.htm](http://www.uams.edu/cmefd/cme2.htm)

## Primary Care Practice Opportunity

**Clinic-based primary care opportunity for Internal Medicine for Cleveland County, Arkansas, a health professional shortage area. Available to applicants with authorization to work. Send CV, with salary requirements and references to Jefferson Regional Medical Center, 1515 West 42nd Avenue, Pine Bluff, AR 71603, ATTN: Sharon Theriot.**





## Use of Diffusion-Weighted Images

**AUTHORS:** SCOTT M. SCHLESINGER, MD; ALONZO R. BURBA, MD  
**EDITOR AND AUTHOR:** STEVEN R. NOKES, MD

### History

A 34-year-old man presented with a low-grade fever and new onset seizures. An MR scan was performed (Figures 1-4).

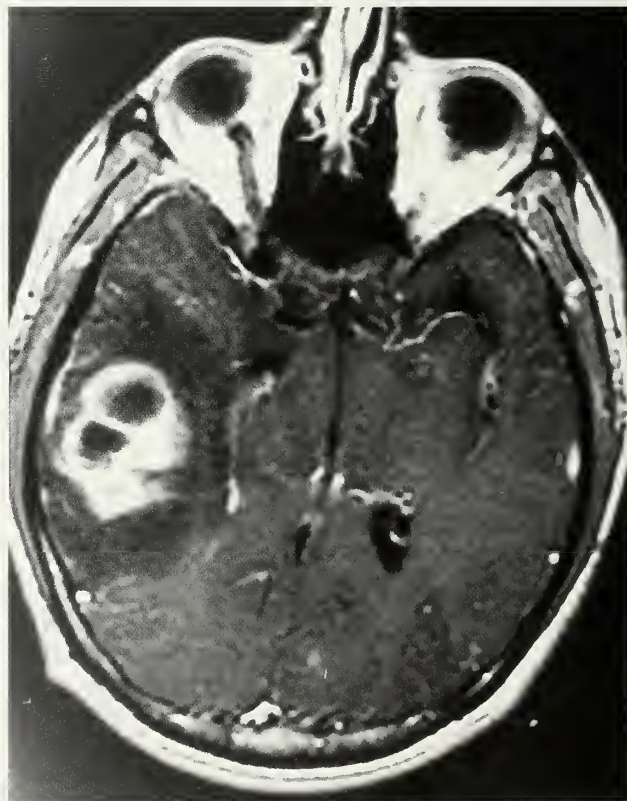
### Findings

The precontrast gradient  $T_1$  weighted image (Figure 1)

reveals a low-signal lobular mass with a high-signal capsule and surrounding vasogenic edema in the right temporal lobe, with mild compression of the cerebral peduncle. Following contrast administration (Figure 2), irregular rim enhancement occurs. The  $T_2$  weighted image (Figure 3) demonstrates loss of signal (dark) in the capsule due to

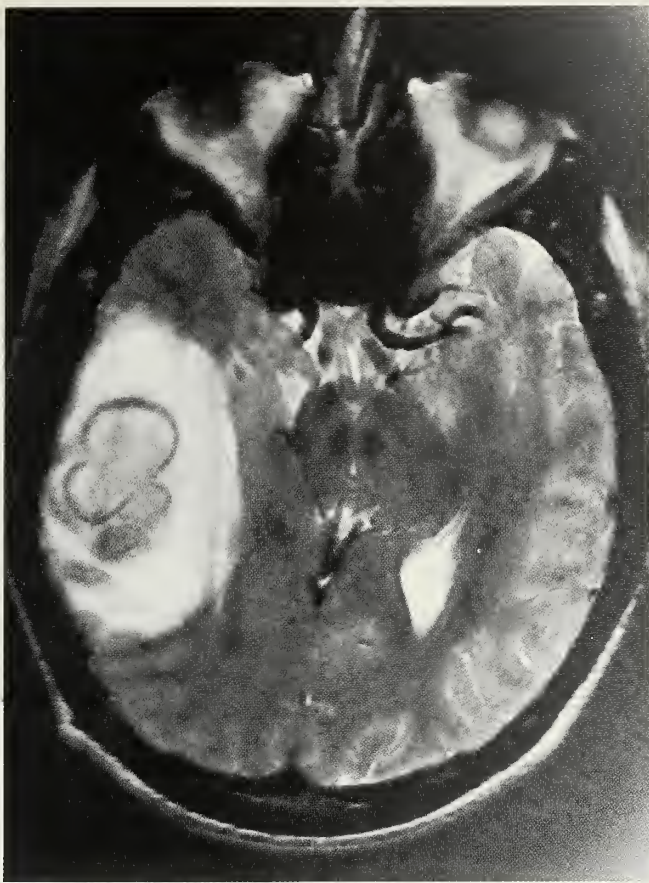


**Figure 1.** Gradient  $T_1$  (TR 225 TE 4.2) weighted axial image of the brain.

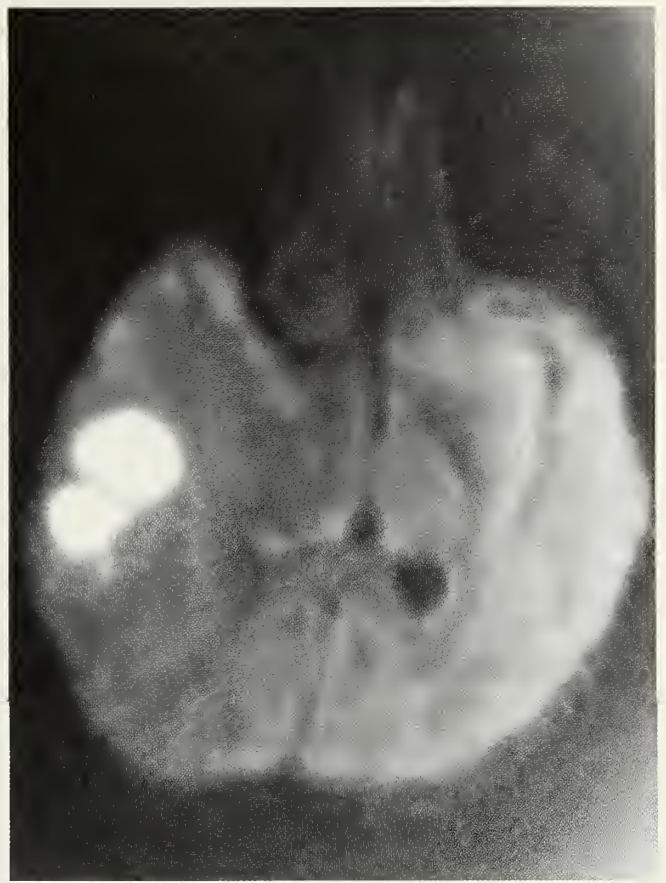


**Figure 2.** Post contrast  $T_1$  weighted (500/11) image.





**Figure 3.** T<sub>2</sub> weighted (4000/86 ef) fast spin echo.



**Figure 4.** Diffusion-weighted image.

paramagnetic effects. The center of the abscess is inhomogeneous. The vasogenic edema is best appreciated on this sequence as bright. On diffusion-weighted images (DWI) (Figure 4), the central abscess cavity is very bright and the vasogenic edema is almost imperceptible.

### **Diagnosis:** Brain abscess

### **Discussion**

Brain abscesses are potentially fatal lesions. The mortality has decreased from approximately 40% to less than 5% since the advent of CT. CT and MR both reveal ring-enhancing lesions in cases of intracranial abscess. This is a nonspecific finding also seen in primary brain tumors, metastases, resolving hematomas, infarcts and, occasionally, demyelinating disease.

MR typically reveals a thin low signal rim on long TR/TE images and high signal rim on short TR/TE images, which is helpful in suggesting the diagnosis. This is due to paramagnetic effects from hydroxyl radicals in macrophages in the collagenous capsule.

More recently, diffusion-weighted images have become available on most MR scanners. These images are usually obtained to look for acute infarcts but have been found to be useful in distinguishing abscesses from necrotic tumors. Image contrast on DWI is based on microscopic motion of water molecules. Normally, this motion is random (Brownian motion).

A process, which restricts free water motion, will appear

bright on trace DWI images. In cerebral infarcts, cytotoxic edema is bright due to swollen cells reducing the translational motion of extracellular water. In abscesses, the central cavity contains a complex mixture of proteins, inflammatory cells, cellular debris and bacteria. The water molecules in this environment are bound to various macromolecules restricting Brownian motion and resulting in increased signal on DWI. The central cavity of necrotic tumors is a much more homogeneous environment and is usually low signal on DWI. Diffusion imaging usually requires strong echo-planar gradients, which are becoming commonplace on high-field-strength magnets. ■

*Dr. Nokes is with Radiology Consultants of Little Rock. Dr. Schlesinger is affiliated with St. Vincent Infirmary Medical Center in Little Rock, and Dr. Burba is in private practice in Little Rock.*

### **References:**

1. Castillo M, Mukherji SK. Diffusion-weighted imaging in the evaluation of intracranial lesions. *Semin US, CT and MRI* 2000; 21: 405-416.
2. Desprechins B, Stadnik T, Koerts G, Shabana W, Breucq C, Osteaux M. Use of diffusion-weighted MR imaging in differential diagnosis between intracerebral necrotic tumors and cerebral abscesses. *AJNR* 1999; 20: 1252-1257.
3. Haimes AB, Zimmerman RD, Morgello S, Weingarten K, Becker RD, Jennis R, Deck MDF. MR imaging of brain abscesses. *AJNR* 1989; 10: 279-291.



# Arkansas Medical Society Insurance Programs....



**AMS BENEFITS, INC.**

A wholly owned subsidiary of the  
Arkansas Medical Society

P.O. Box 55088

Little Rock, Arkansas 72215-5088

(501)224-8967

WATS 1-800-542-1058

FAX (501) 224-6489

"Available products include group  
health, office package, professional  
liability, home, auto, and more."

*tailor-made for physicians*

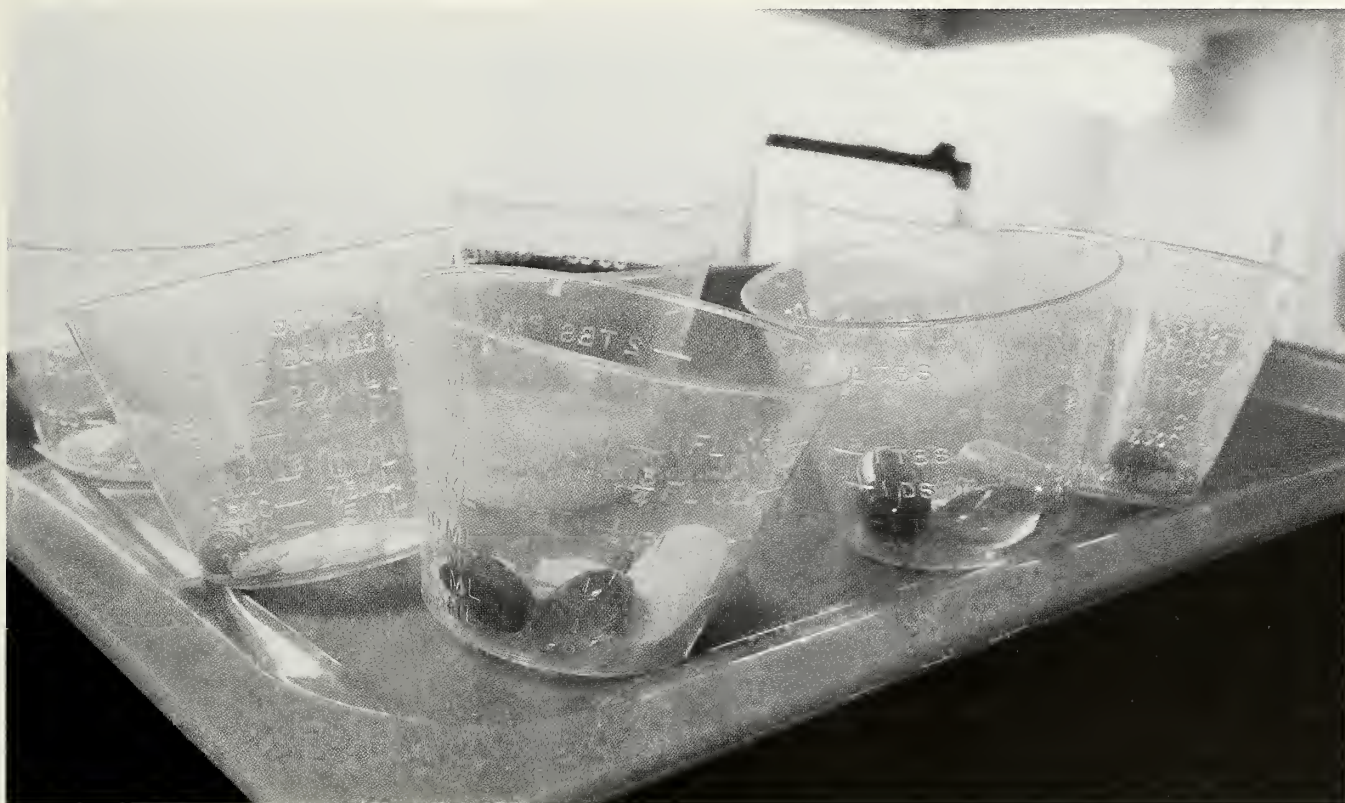
Insurance products are a fact of life. You can buy them almost anywhere. Fortunately there's one agency that only represents physicians...Arkansas physicians. AMS Benefits, with products to meet both your professional and personal needs.

Call us at 1-800-542-1058 or 501-224-8967



# Arkansas Patient Safety Initiative

EDITORIAL PANEL: WILLIAM E. GOLDEN, MD; DEBORAH L MARPLE, RN, BS, CPHQ;  
DONNA S. WEST, PHD



*The Arkansas Foundation for Medical Care is developing quality improvement projects geared to patient safety, such as studying issues involved with appropriate dosing for pediatric and geriatric patients.*

BY WILLIAM E. GOLDEN, MD



**O**ne year after the release of the groundbreaking Institute of Medicine report "To Err is Human: Building a Safer

Health System," state health care leaders have joined forces to enhance patient safety in Arkansas.

The Arkansas Patient Safety Initiative (APSI) is the effort of the major statewide health care organizations in Arkansas that came together after the Institute of Medicine reported that as many as 98,000 patients die each year in the United States as a result of medical errors.

Providing health care is a very complex business. A single patient in the hospital for three to five days

probably received hundreds of services provided by thousands of interactions with, and "handoffs" to, numerous health professionals ranging from physicians to nurses to X-ray technicians to transport aides. Even with an accuracy rate of 99.9%, there would be one error for every 1,000 handoffs in a hospital setting. The average patient most likely has a few thousand handoffs during a typical hospital stay.

Arkansas Foundation for Medical Care (AFMC) is the Peer Review and Quality Improvement Organization for Medicare and Medicaid in Arkansas. AFMC works collaboratively with providers, community groups and other stakeholders to promote the quality of care in Arkansas through evaluation and education. For more information about AFMC quality improvement projects, call 800-272-5528, ext. 204.



Many experts believe that the key to ensuring patient safety is preventing medical errors from occurring in the first place. Most safety risks do not result from individual carelessness, but rather can be attributed to limitations in processes an organization has put in place. The risks to patient safety are manageable when effective systems are in place to ensure safety. This alliance of leaders can work closely with their respective constituents and members to promote improved systems.

## Arkansas Patient Safety Initiative



What can and should be done to reduce medical errors in our health care system? Some solutions lie in better education, reminder systems and safeguards.

Other solutions lie in better information technology that works to assist caregivers at the point of service in monitoring and controlling processes employed on behalf of a patient.

Members of the Arkansas Patient Safety Initiative believe that much can be done to enhance the patient-care environment through cause analysis and sharing of best practices. Mandatory reporting systems, by definition, bring about defensiveness and concerns over the use of the quantitative data. Moreover, voluntary systems of environmental assessment and quality improvement, when matched with a regional collaborative educational framework, can achieve as much, if not more, than

the mere counting of events. It is the goal of APSI to monitor the trends in research in patient safety and facilitate its dissemination and local adoption and adaptation in Arkansas and thus benefit all patients and facilities in our community.

Members of APSI are free to pursue their own initiatives for their members and constituencies in patient safety. APSI will serve as a clearinghouse to promote the activities of its members and to share new information on this important topic. In addition, there will be periodic joint initiatives to promote the core concepts in patient safety.

This March, APSI sponsored its first statewide conference on patient safety and featured local and national speakers with experience in focused initiatives to enhance the patient-care environment. Issues included pediatric sedation, the ethics of error disclosure, common errors in prescription writing and broad national overviews from Dr. Steven Small of the University of Chicago Patient Safety Center and Mary Foley, president of the American Nursing Association. Clinical staff leaders from Washington Regional Medical Center in Fayetteville and Baptist Medical Center in Little Rock discussed processes and programs at their facilities to address patient safety and medical error. APSI plans to offer additional seminars and training in root cause analysis as this effort unfolds.

In addition to such public forums, the Arkansas Foundation for Medical Care is developing quality improvement projects geared to patient safety. For example, it will be looking at issues involved with appropriate dosing for pediatric and geriatric patients as well as the appropriate use of perioperative antibiotics to avoid postoperative

wound infections. Appropriate timing of perioperative antibiotics can reduce wound infection by more than 80%. Nevertheless, there is frequently up to a 20% failure rate to deliver antibiotics within a two-hour time window before the first surgical incision.

Use of systems interventions such as checklists or procedures to ensure documentation and execution of core critical health processes can go a long way toward supplementing professional education and enhancing vigilance.

Improving patient safety requires freedom to report errors and an educational environment to address core issues responsible for their genesis. A shared bad experience at one institution can create opportunity for the health professional community and its facilities to avoid similar episodes in its own local environment. The APSI aims to change the climate by creating an educational, nonpunitive forum in which questions and critical events can be discussed openly so that solutions can be implemented.

The APSI gives Arkansas providers the opportunity to discuss potential and past safety issues openly in hopes of finding solutions and improving care. The Arkansas health care community believes that its patients deserve focused attention on patient safety and, through collaborative planning and communication, can provide the opportunity and forum for constructive dialogue and information dissemination to facilitate adoption of new measures to make health care more effective in our communities.

Will error go away completely? Probably not. Health care is a very personal, tailored and resource-intensive undertaking. Can the health care system do a better job? Absolutely. It just takes the commitment, the data, the leadership and innovation to make it happen. ■



# Pediatric Injuries Resulting from Use of All-Terrain Vehicles

DANIEL LANCE BERCHER, M.ED., B.S., NREMT-P — KELLY STALEY, MD — LORI W. TURNER, PH.D., R.D. — MARY AITKEN, MD

## Abstract

Annually, 20,000 children are injured while operating all-terrain vehicles (ATVs).

The purpose of this paper was to review child-ATV injuries in Arkansas and identify any areas in need of further investigation. An analysis of emergency-medical-service transports was done for children 0-19 years who had ATV-related injuries in Arkansas from 1998 to 1999. Prehospital-reported child-ATV emergencies were identified, separated by county, and emergency encounter rates were calculated. Our results indicate that emergency medical services (EMS) transported 319 children in Arkansas from 1998 to 1999. ATV injury information is limited in Arkansas, but available data indicate high injury rates existed for many rural counties.

## Introduction

In 1997, an estimated 20,000 children were injured while operating or riding an all-terrain vehicle (ATV).<sup>1</sup> Even after efforts were made by the U.S. Consumer Product Safety Commission (CPSC) in 1988 to limit ATV manufacturer and sales practices, the rate of child-related injuries on ATVs has been unchanged.<sup>1</sup> At least 90% of children injured on ATVs were operating vehicles rated for an adult size.<sup>2</sup>

## Characteristics of ATVs

An ATV is a three- or four-wheeled motorized vehicle powered by a gasoline engine smaller in size and weight than most road-licensed vehicles. The tires are designed for gripping rough terrain and are not likely to skid on paved surfaces. The engine displacement for ATVs ranges from 50-500 cm.<sup>3</sup> They can weigh up to 600



*Emergency medical services transported 319 patients under 20 as the result of an ATV-related injury over a two-year period, from 1998-1999.*

pounds and reach speeds up to 60 mph. ATVs are designed for use by a single rider. Although the seat appears large enough to accommodate multiple riders, it is actually intended for one person. Riders can shift, adjust and balance their weight distribution in rough terrain situations.

All-terrain vehicles have been manufactured since 1971. The sales of ATVs skyrocketed in the 1980s. With the increasing use of ATVs came an equally escalating morbidity and mortality due to injuries. From 1983 to 1986, there was a 300% increase in emergency department treatment for ATV-related injuries.<sup>3</sup>

As a response to this realization, the

CPSC became involved and helped ban the production of three-wheelers through 1988. In addition, the CPSC entered into a 10-year binding consent decree that involved improved warning labels, restrictions of the sales of adult-size ATVs for use by children less than 16, industry voluntary standards for safer vehicles and implementation of a nationwide training program.

A one-time registration fee must be paid to the Department of Finance, but no driver's license is required under existing Arkansas law. Children over 12 can legally operate ATVs on their own. Children under 12 can operate ATVs with adult supervision. Operation of ATVs on public highways is unlawful,



but riders are allowed to cross highways to get to another field.

A national survey of ATV operators revealed that 25% of the drivers engaged in difficult maneuvers such as doing wheelies.<sup>4</sup> More than half (53.7%) admitted that they were carrying passengers. Only 11% had ever taken a formal ATV driving course, and 32% admitted that they never wore a helmet.

### **Mechanism of Injury and Mortality**

The CPSC reported that the two most frequently reported hazard patterns associated with ATV-related deaths were collisions (56%) and overturns (35%).<sup>1</sup> More than half of all collisions occurred with a stationary object, while 35% occurred with another motorized vehicle. An additional 11% of the collisions involved another person or an animal. Overturns were usually the result of the operator losing control or they occurred while riding up or down a hill. Backward overturns were more common than forward overturns. Sixty percent of the deaths occurred on roadways and 29% occurred on paved roads. Only 1% of the deaths occurred on actual ATV trails.

Even though three-wheeled ATVs have not been manufactured since 1988, they still account for 25% of all ATV-related injuries.<sup>2</sup> These ATVs were regarded highly dangerous secondary to their high center of gravity and front-wheel brakes that predispose the vehicles to rollovers, flipping backward and instability in negotiating turns. Three-wheel ATVs are two-and-a-half to three times more likely to cause injury than four-wheel ATVs.

### **Risk Factors**

Two important risk factors are large engine size and male operators. Increasing engine size appears to correspond to increasing probability of injury. Engines greater than 200 cc's contribute to 83% of the ATV injuries.<sup>2</sup>

### **Populations at Risk**

Similar to other high risk-taking behaviors, the population of males under

16 is vastly overrepresented in the ATV injury pool. In addition, male drivers are three times more likely to experience injury. Furthermore, this effect decreases with age.

Children constitute 14% of all ATV drivers but are responsible for a staggering 40% of all injuries. Interestingly, this ratio of injuries has remained fairly stable since 1985.<sup>1</sup>

### **Purpose**

The purpose of this report was to explore pediatric injuries related to all-terrain vehicles in Arkansas. A second objective was to identify areas worthy of further investigation.

### **Methods**

The Arkansas Department of Health Division of Emergency Medical Services and Trauma Systems (DEMS) has implemented a statewide data program that includes every emergency run that prehospital-care providers must complete when a patient has been encountered. The data system includes information such as patient age, nature of the emergency, and location. An analysis was completed using all encounter forms dated Jan. 1, 1998, and Dec. 31, 1999, for patients aged 0 to 19, with "all-terrain vehicle" reported as the nature of the emergency. All demographic, emergency care, helmet use and related injury data were tabulated. In addition, the location of the emergency medical services (EMS) encounter was defined as the county where the emergency scene was reported.

An estimate of the rate of ATV-related injury in Arkansas children was calculated using the EMS data and county-specific 1990 census data. The counties in west, northwest and north-central Arkansas were classified as mountainous; the central counties were classified as varied; and southern and eastern counties were designated flat.

### **Results**

The available data indicated that Arkansas EMS transported a total of 319 patients under 20 as the result of an ATV-related injury over the two-year period. Males accounted for 65.2%

of all the patients. Only 6% of patients reported wearing a helmet. Seventy-seven percent of the children were under 16. The most common location was reported as "other traffic way" (which is defined as any other road than a highway with speeds at or above 55 mph) in 37.6% of the cases. A residence was reported to be the second most common location, at 16.3%. Patient ejections were reported in 10% of the cases, while rollovers were reported 8.8% of the time.

Although Van Buren County had the highest child-ATV EMS encounter rate, at 255 per 100,000, the actual population of the county ranked 48th among the 75 Arkansas counties. Van Buren County also had a mountainous terrain classification (See Table). Pulaski County, on the other hand, had an ATV-child EMS encounter rate of 11 per 100,000, which ranked 66th. Pulaski is the most populous county in the state (See Table).

### **Discussion**

The purpose of this article was to explore pediatric injuries related to all-terrain vehicles in Arkansas based on prehospital emergency encounter reports. Several patterns emerge from these EMS data. Seven of the top 10 child-ATV-rated counties were in the mountainous terrain of the north and northwest regions of the state. For example, Madison County in northwest Arkansas had the fifth highest ATV-child EMS encounter rate. Madison County was only ranked 56th by population (See Table).

Among Arkansas' three most populous counties — Pulaski, Washington and Sebastian — the ATV-child EMS encounter rates were markedly lower, with rankings of 66th, 58th and 65th respectively (See Table). The available evidence suggests that higher EMS encounter rates with child-ATV incidents occur in less populous, mountainous counties.

Since Arkansas, like many states, does not track all emergency department admissions, it is not known how many patients were actually treated

## Arkansas Prehospital-Reported ATV Emergency Encounters for 1998-1999 (for Children 0-19 among the 75 counties)

ATV Injury Rank	Arkansas County	ATV Injury Rate per 100,000	Total # Injured	General Terrain Classification	Total Population 0-19 years	Population Rank
1	Van Buren	255	8	Mountainous	14,008	48
2	Cleburne	237	10	Mountainous	19,411	33
3	Fulton	211	5	Mountainous	10,037	62
4	Clark	209	10	Flat	21,437	31
5	Madison	161	5	Mountainous	11,618	56
6	Lafayette	150	4	Flat	9,643	64
7	Perry	149	3	Mountainous	7,969	68
8	Clay	144	6	Flat	18,107	39
9	Newton	140	3	Mountainous	7,666	72
10	Polk	135	6	Mountainous	17,347	42
66	Pulaski	11	10	Varied	349,660	1
58	Washington	32	9	Mountainous	113,409	2
65	Sebastian	15	4	Mountainous	99,590	3

secondary to an injury received as the result of ATV operation. Furthermore, since the majority of ATV accidents occur in rural settings, it is highly likely that some individuals choose not to wait for emergency medical services due to extended ambulance response times. The actual number of EMS transports very likely underrepresents the grand total number of ATV-child-associated injuries. Unfortunately, the degree of this underrepresentation is unknown.

A second objective of this study was to identify areas worthy of further investigation. The actual number of children injured while riding ATVs in Arkansas is not known, and further information about the degree of exposure of this population would be helpful in targeting interventions. Further, the development of a comprehensive trauma system that tracks all patients could facilitate an assessment for the potential impact of injury prevention programs. Since the likelihood of such a comprehensive program being implemented any time soon is doubtful, individual case studies and assessments at the county level for child-ATV injuries could shed some light on this issue.

The fact that higher rates of EMS encounters occurred in the rural counties suggests that there may be a large

population of young people who are riding ATVs unsupervised in the pastures and backwoods of the state. More public education and ATV awareness programs may be warranted, especially for counties with high child-ATVEMS encounter rates.

The American Association of Pediatrics (AAP) recommends that ATV operation should be limited to children and adults who are old enough (at least 16 years old) to legally operate an automobile.<sup>5</sup> Arkansas state law, in contrast, allows children 12 years and older to operate ATVs with no adult supervision. Wider dissemination of the AAP recommendations and implementation of the guidelines could form the foundation of broader prevention programs for the state.

Although the actual health care costs and number of debilitating incidents associated with child-ATV injuries are unknown, it appears that many children in the state are at risk for ATV injury. Comprehensive educational efforts and the consideration of aggressive, regulatory interventions for ATV use, especially in young children, may reduce the number of these preventable injuries. ■

*Dr. Bercher is interim chairman of the department of emergency medical sciences at the University of Arkansas for Medical*

*Sciences. Dr. Staley is a physician at the Conway Children's Clinic. Dr. Turner is assistant professor of health sciences at the University of Arkansas in Fayetteville. Dr. Aitken is assistant professor of pediatrics at Arkansas Children's Hospital.*

### References

1. U.S. Consumer Product Safety Commission, Washington, D.C.: Notice, Federal Register 63(174). Sept. 9, 1998.
2. U.S. Consumer Product Safety Commission. *National Electronic Injury Surveillance System*. Washington, D.C.: US Consumer Product Safety Commission; 1994-1996.
3. U.S. Consumer Product Safety Commission. Annual Report of ATV Deaths and Injuries. Washington, D.C.: U.S. Consumer Product Safety Commission; Aug. 30, 1999.
4. Rodgers GB. Part I, Report on 1997 ATV Exposure Survey. Bethesda, MD: U.S. Consumer Product Safety Commission, 1998.
5. American Academy of Pediatrics, Committee on Injury and Poison Prevention. All-Terrain Vehicle Injury Prevention: Two-, Three-, and Four-Wheeled Unlicensed Motor Vehicles. *Pediatrics* 2000;105:1352-1354.



# PEOPLE+EVENTS

## HONORED

### Physicians Receive Awards from AMA

Each month the American Medical Association presents the Physician's Recognition Award to those who have completed acceptable programs of continuing education.

AMA recipients for December are **Dr. Jerry A. Alexiou** of Little Rock, **Dr. Peggy J. Brown** of Searcy and **Dr. Ivory A. Kinslow** of El Dorado.

## OBITUARIES

### Frederick C. Turner, MD

Dr. Frederick C. Turner, 58, died Nov. 28, 2000. He was a resident of Mountain Home and practiced at Pigeon Creek Medical Center. Dr. Turner graduated in 1968 from the University of Texas Medical Branch, Galveston. He is survived by his wife.

### Rolland F. Broach, MD

Dr. Rolland F. Broach, 80, of Little Rock died Dec. 27, 2000. He was a 1945 graduate

of the University of Arkansas for Medical Sciences and was a practicing psychiatrist in Searcy.

He is survived by two sons, Mark Broach and Greg Broach, both of Little Rock; a daughter, Cathy Broach of Kansas City, Mo., three grandchildren; and one great-grandchild.

### Robert Edwin Elliott, MD

Dr. Robert Edwin Elliott, 60, of Searcy died Jan. 13. Dr. Elliott was a partner in the Arkansas Radiology Group,

P.A., in Searcy, a graduate of the University of Arkansas for Medical Sciences and a member of Trinity Episcopal Cathedral.

He is preceded in death by his mother, Gordie Lee Bethea Elliott. He is survived by his wife, Marilyn Pauli Elliott; a son, Mark Elliott of Searcy; a daughter, Leigh Ann Bennett of Little Rock; his father, Ed Elliott of Searcy; a brother, Hollis Elliott of Tuckerman; a sister Ann Dunham of Normal, Ill.; and a granddaughter. ■

## New Members

### Robert M. Jarvis, MD

Specialty: Resident-P  
58 Warwick Road  
Little Rock, AR 72205  
(501) 224-5262

### Sandra Johnson, MD

Specialty: D  
4301 W. Markham St., #576  
Little Rock, AR 72205  
(501) 686-5110

### Karla R. Jones, MD

Specialty: Resident-FP  
4010 Mulberry St.  
Pine Bluff, AR 71603  
(870) 541-6010

### Amir L. Kellow, MD

Specialty: Resident-AN  
4301 W. Markham St., #515  
Little Rock, AR 72205  
(501) 686-6114

### Delaney L. Kinchen, MD

Specialty: Resident-EM  
5901 JFK Blvd., #4302  
North Little Rock, AR 72116

### Kevin R. Koehler, MD

Specialty: Resident-FP  
460 W. Oak St.  
El Dorado, AR 71730  
(870) 862-2489

### Richard E. Kremp, MD

Specialty: R  
500 S. University Ave., #108  
Little Rock, AR 72205  
(501) 664-3914

### Gregory Laffoon, MD

Specialty: GS  
1900 Malvern Ave.  
Hot Springs, AR 71901  
(501) 624-5700

### Debra C. Lawrence, MD

Specialty: OBG  
525 Western Ave., #205  
Conway, AR 72032  
(501) 450-3920

### George S. Lawrence, MD

Specialty: FP  
630 Burnett  
Mountain Home, AR 72653  
(870) 425-6971

### Rachel J. Lehmkuhl, MD

Specialty: Student  
4301 W. Markham St.  
Little Rock, AR 72205  
(501) 686-5516

### Fangru Lian, MD

Specialty: Resident-PTH  
4301 W. Markham St.  
Little Rock, AR 72205  
(501) 686-5444

### Mark Elwood Linskey, MD

Specialty: NS  
4301 W. Markham St. # 507  
Little Rock, AR 72205-7199  
(501) 686-6979

### Eric D. Long, DO

Specialty: Resident-FP  
2907 E. Joyce Blvd.  
Fayetteville, AR 72703  
(501) 521-8260

### Ellen Lu, MD

Specialty: Resident-IM  
4301 W. Markham St.  
Little Rock, AR 72205  
(501) 686-6560

### Nicholas P. Luzietti, MD

Specialty: OBG  
101 Skyline Drive  
Russellville, AR 72081  
(501) 890-7125

### George J. Madera, MD

Specialty: CD  
1609 W. 40th St., #201  
Pine Bluff, AR 71603  
(870) 536-3015

### Mustafa Mahdavy, MD

Specialty: Resident-PTH  
4301 W. Markham St.  
Little Rock, AR 72227  
(501) 686-8657

### Michael J. Mancino, MD

Specialty: Resident-P  
4301 W. Markham St., #589  
Little Rock, AR 72205  
(501) 686-5483

### Brett H. May, MD

Specialty: GS  
505 Hospital Drive  
Mountain Home, AR 72653  
(870) 425-9120

### Brian P. McAndrew, MD

Specialty: PS  
10809 Executive Center  
Drive, #100  
Little Rock, AR 72211  
(501) 227-0707

### Emily M. McNellis, MD

Specialty: Resident-PD  
800 Marshall St.  
Little Rock, AR 72202-3591  
(501) 320-1100

### Ryan E. McNellis, MD

Specialty: Resident-IM  
4301 W. Markham St.  
Little Rock, AR 72205  
(501) 686-5444

### Jason A. Merrick, MD

Specialty: Resident-FP  
4010 Mulberry St.  
Pine Bluff, AR 71603  
(870) 541-6000

**Toni L. Middleton, MD**

Specialty: FP  
1400 W. 43rd St.  
Pine Bluff, AR 71603  
(870) 535-6461

**Mashhud Munir Mirza, MD**

Specialty: NEP  
228 Tyler, # 308  
West Memphis, AR 72301  
(870) 732-5803

**Katherine B. Mitchell, MD**

Specialty: FP  
10000 Rodney Parham Road  
Little Rock, AR 72227  
(501) 221-0888

**Justin E. Morgan, MD**

Specialty: Resident-OTO  
14008 Sweet Bay Drive  
Little Rock, AR 72211

**Mark Moss, MD**

Specialty: Resident  
6518 Longwood  
Little Rock, AR 72207

**Muhammad T. Munir, MD**

Specialty: Resident-FP  
521 S. Elm St., #530  
Little Rock, AR 72205  
(501) 686-6560

**John R. Nolen, MD**

Specialty: Resident-FP  
612 S. 12th St.  
Fort Smith, AR 72901  
(501) 785-2431

**Eduardo R. Ochoa Jr., MD**

Specialty: PD  
800 Marshall St.  
Little Rock, AR 72202  
(501) 320-4361

**Lila Pappas, MD**

Specialty: FP  
2602 St. Michael Drive  
Texarkana, TX 75503  
(903) 614-6000

**Paul H. Pappas, MD**

Specialty: FP  
2602 St. Michael Drive  
Texarkana, TX 75503  
(903) 614-6000

**Paul J. Parcon, MD**

Specialty: FP  
2001 S. Main St., #4  
Hope, AR 71801  
(870) 722-6378

**Paige M. Partridge, MD**

Specialty: OBG  
3336 N. Futrall  
Fayetteville, AR 72703  
(501) 521-4433

# Professional Banking With World Class Service.



If you are an executive or professional with limited time, contact Metropolitan's Professional Banking Group today at 501-978-7631.

George Penick (left)  
*Senior Vice President*

Dexter Lewis (right)  
*Assistant Vice President*

 **Metropolitan  
National Bank**  
**World Class Banking.  
Nearby & Neighborly.**

Little Rock, North Little Rock, Sherwood, Benton, Bryant, Conway  
www.metbank.com • Member FDIC



## Healthcare Professional Liability Business/Workers' Compensation/ Life & Retirement Planning

Managing the business side of healthcare is time consuming, but FARMERS helps get you back where you belong—delivering quality medical care.

For almost 50 years, Farmers has been a well respected carrier. We provide the highest quality products and services to all types of physician groups. We know our business.

Our professional team has an established background in medical services and management. We are committed to working in our client's best interests, offering premier claims and risk management services—with coverage especially for the physicians.

*A.M. Best rating of A+ (Superior)*



Mark Perry

112 Municipal Drive • Jacksonville, AR 72076  
(501) 982-4561 • 1-800-467-2436  
mperry@alltel.net



Joanna Owens

712 A Bradley Dr • Mtn. Home, AR 72653  
(870) 424-2120 • 1-888-424-2120  
baxterinsurance@yahoo.com



# Putting the *Care* back in Managed HealthCare



You have a choice about your healthcare plan.  
That's why we've put the *care* back in managed healthcare.

We're Arkansas Managed Care Organization (AMCO) — Arkansas people working to take care of your health. AMCO is a recognized leader in managed healthcare in the state, not only because of our size, but also for our high degree of accountability, outstanding customer service and stability.

Our statewide PPO network offers community care through:

- More than 3,800 physicians and hundreds of other healthcare professionals;
- Services in over 100 hospitals; and,
- An excellent staff representing your best interests.



*Serving employers and their greatest  
asset with quality managed care.*

Call us today at  
**1-800-278-8470 or 501-225-8470.**

#10 Corporate Hill Drive, Suite 200  
Little Rock, Arkansas 72205  
[www.amcoppo.com](http://www.amcoppo.com)





## Pond Mountain Lodge and Resort

Distinctive and secluded, Pond Mountain Lodge and Resort offers stunning woodland views and comfortable, exquisitely decorated rooms. Visitors to the 150-acre resort may choose to stay in either a cozy bed and breakfast inn or a cabin.

The Main Lodge is a large rambling ranch house with a vaulted ceiling, seven-foot fireplace and three adult-only suites with in-room whirlpool tubs. In the lower level of the lodge is a game room with a billiards table. Visitors also can enjoy views of the mountains while relaxing on the 35-foot veranda.

Located just two miles south of Eureka Springs, the resort sits on Pond Mountain, the highest point in Carroll County.

The Pool Suites building has two suites, one with a queen-size bed and two twin-size sleeper sofas — perfect for families. Both suites have a fully equipped kitchen with dining nook and a separate living room, and share a 25-foot deck above the swimming pool with a 30-mile view to the east.

All the suites feature distinctive decorating styles ... from the casual sea coast theme of the Sandpiper suite to the floral fantasy and airiness of the Hummingbird suite.

Two cabins, the Kingfisher and the Roadrunner, give guests an added element of privacy. The A-frame Kingfisher

is an ideal retreat for a romantic getaway or family weekend. The cabin features a fireplace, full kitchen, two-person whirlpool tubs, queen-size bed and sleeper sofa, decks and lofts with scenic views.

Amenities for all guests include two stocked fishing ponds, hiking trails, horseshoes, croquet, horseback riding, a heated swimming pool and in-room whirlpool tubs. Guests are invited to explore any part of the resort's acreage by foot, although driving to the ponds also is permitted. Other highlights include complimentary beverages, coffee service (with gourmet coffee provided), TV/VCRs, a video library with popcorn, microwaves and refrigerators.

All guests, except those staying in the cabins, may enjoy a complimentary full country breakfast buffet each morning served in the luxurious Great Hall or on the veranda.

King suites range in price from \$125-\$140, with queen suites from \$100-\$120. Prices for cabins are \$140 for two persons or \$160 for four persons. Smoking is allowed outdoors only. ■

*Pond Mountain Lodge and Resort, 1218 Highway 23 South, Eureka Springs, AR 72632. For information call (800) 583-8043 or visit [www.eureka-usa.com/pondmtn/](http://www.eureka-usa.com/pondmtn/).*



## ADVERTISERS INDEX

AMS Benefits Inc. ....	348
Arkansas Business.Com .....	Inside back cover
Arkansas Financial Group Inc., The .....	334
Arkansas Foundation for Medical Care .....	328
Arkansas Managed Care Organization .....	356
Asti, William Henry, AIA .....	331
Central Arkansas Radiation Therapy Institute .....	342
Central Flying Service .....	341
Chenal Properties .....	332
Farmers Insurance Group .....	355
GuestHouse Inn.....	331
Health Data Services, LLC .....	333
Jefferson Regional Medical Center .....	345
Maggio Law Firm .....	334
Mary Healey's Fine Jewelry .....	330
Metropolitan National Bank.....	355
Micheal Munson, A.G. Edwards & Sons Inc. ....	327
Online Technologies Inc. ....	358
Professionals Advocate .....	Inside front cover
Pro Travel .....	330
Regions Bank .....	358
Residence Inn .....	333
Riverside Motors .....	339
State Volunteer Mutual Insurance Co. ....	Back cover
University of Arkansas for Medical Sciences .....	341
University of Arkansas for Medical Sciences Continuing Education .....	345

Special Publications  
Publisher  
*Brigette Williams*

Special Publications  
Editor-in-Chief  
*Natalie Gardner*

Managing Editor  
*Shelby Brewer*

Copy Editor  
*Donna Schratz*

Editorial Assistant  
*Susan Van Dusen*

Sales Manager  
*Stephanie Hopkins*

Account Executive  
*Liz Earlywine*

Director of Design  
and Circulation  
*Virgeen Healey*

Production and  
Circulation Coordinator  
*Jeremy Henderson*

Editorial Art Director  
*Irene Forbes*

Advertising Art Director  
*Nikki Cruse*

Photographer  
*Mark Wilson*

Advertising Coordinator  
*Kristen Heldenbrand*

Marketing Assistant  
*Mitzi Tiffie*

Database Administrator  
*Andrea Martin*

Advertising Assistant  
*Greg Duszota*

 **ARKANSAS BUSINESS  
PUBLISHING GROUP**

Chairman & Chief Executive Officer  
*Olivia Farrell*

President and Publisher  
*Jeff Hankins*

Executive Vice President  
*Sheila Palmer*

© 2001 Arkansas Business Publishing Group  
www.abpg.com

## ACHIEVING SUCCESS ENTITLES YOU TO PRIVILEGES IN LIFE

Achieving your personal goals often requires a planned balance of financial management, including checking, loans, trust, investment products\* and services.

At Regions, we offer Private Banking to complement your success. We provide a level of service to efficiently meet your needs and maximize your valuable time. Whether you require business or personal services, you can rely on one of our private bankers to help ensure your goals are met by providing uncompromising, convenient service. To find out more about the special attention you deserve, please call us today.

Contact our Private  
Banking Department  
371-6613

**PRIVATE  
BANKING**

**Regions Bank**

www.regionsbank.com



\* Investments purchased through Regions Investment Company, Inc. are not deposits of the bank or guaranteed or insured by the bank, the FDIC or any government agency. Investments can assume risk including loss of principle. Regions is a member of NASD and SIPC.

MEMBER  
FDIC

**Audio, Visual  
Equipment for Your  
Home or Office.**



NEC PlasmaSync 42MPI

**ONLINE**  
TECHNOLOGIES INC  
SINCE 1985



10307 Maumelle Blvd  
NLR, AR 72213  
224-3906 • 1-800-687-4647  
www.onltech.com



# Surfing the Net in Arkansas just got better.

- FREE statewide business news delivered daily by e-mail
- FREE industry-specific E-newsletters delivered weekly
- Search for office space, meeting sites & Arkansas Web sites
- Submit & search information — new employees, new businesses, calendar of events
- Search archives of *Arkansas Business*, *Northwest Arkansas Business Journal* & Daily Reports

The State's **#1**  
Source for  
**Arkansas**  
Business Information



ARKANSAS  
BUSINESS.COM

For sponsorship opportunities, contact Jeff Hankins  
at 372-1443 or [jhankins@abpg.com](mailto:jhankins@abpg.com)





*Guess who comes up short if your malpractice insurer doesn't quite measure up.*

**M**alpractice insurers are most definitely not created equal. And absolutely none are as wise, strong and fiscally fit as SVMIC. In fact, most others are just a little puny, in one way or another. With 25 years of experience in medical malpractice insurance, SVMIC is exactly the kind of company you want standing with you, when feeling ten feet tall is really most comforting. No excuses. No running for cover. Nothing else that we'd rather be doing. Malpractice insurance is our only business. As physicians, we at SVMIC truly understand what's at stake during potentially catastrophic litigation. After 25 years of standing tall, we're not about to back down now.



State Volunteer  
Mutual Insurance  
Company

For more information, contact Susan Decareaux or Thad DeHart • P.O. Box 1065 Brentwood, TN 37024-1065  
e-mail: [svmic@svmic.com](mailto:svmic@svmic.com) • Web Site: [www.svmic.com](http://www.svmic.com) • 1-800-342-2239 • (615) 377-1999

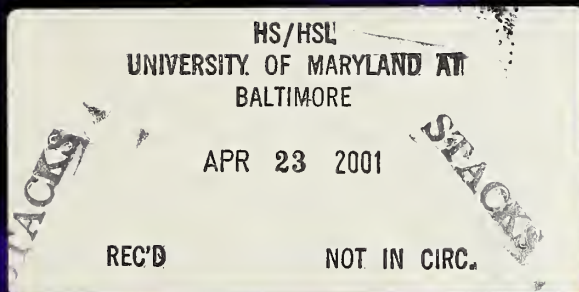


# THE Journal

OF THE ARKANSAS MEDICAL SOCIETY

Vol. 97 No. 11

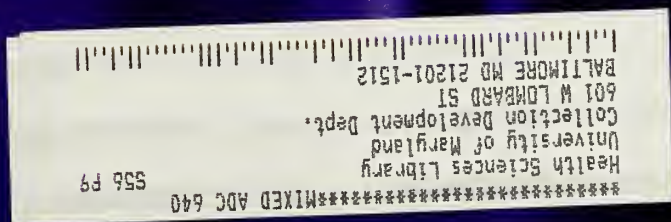
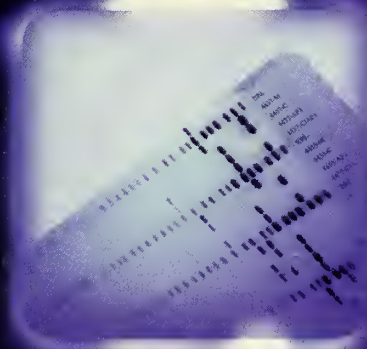
May 2001



**125th AMS  
Annual Session**

## **Building on the Foundation**

125 YEARS OF MEDICINE





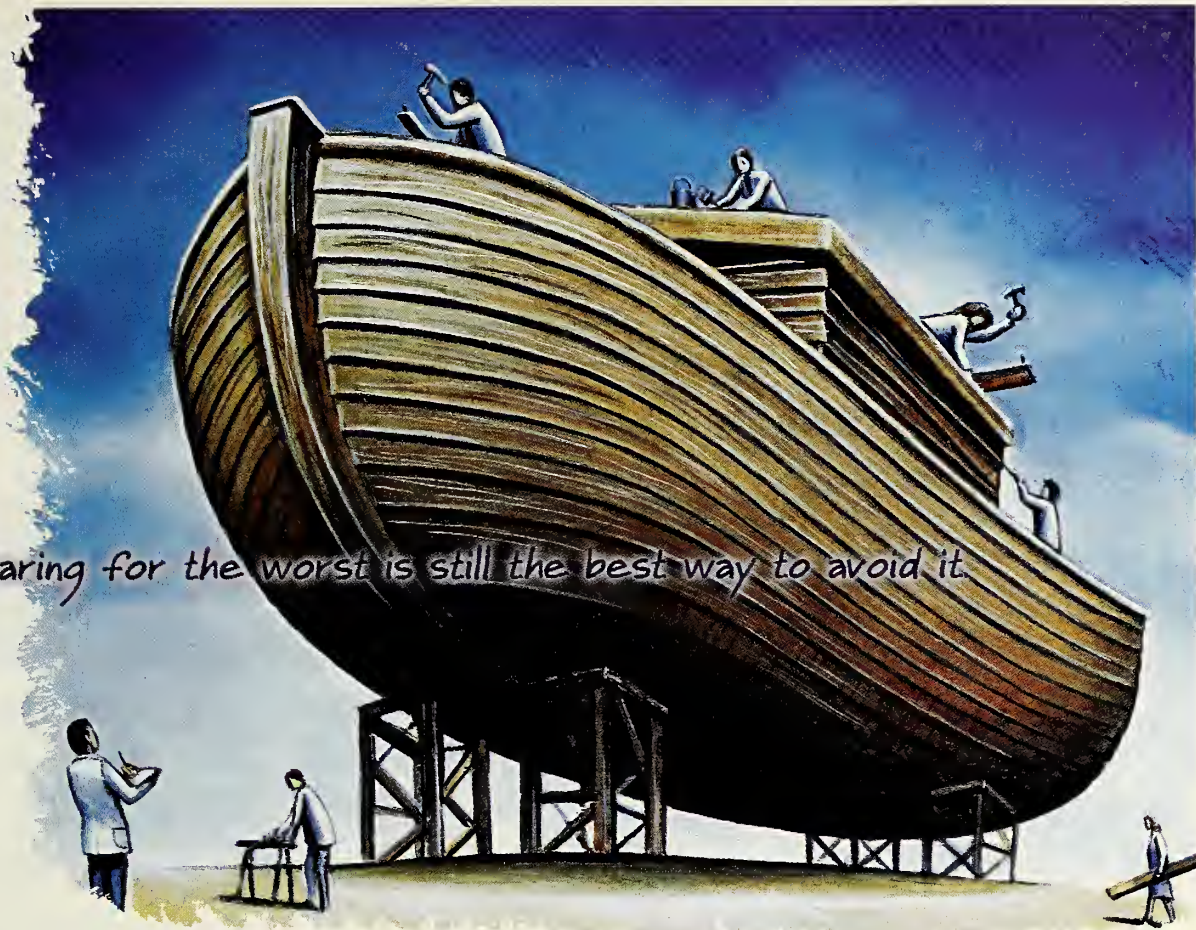
{ PATIENT'S SMILE }

**YOU LOSE A LOT WHEN YOU LOSE YOUR SIGHT. PREVENT DIABETIC BLINDNESS.**

AFMC encourages Medicare and Medicaid providers to refer their diabetic patients to an eye care professional for an annual dilated eye exam. For more information on the AFMC Health Care Quality Improvement Program, call **1-877-650-AFMC.**



*Arkansas Foundation  
for Medical Care*



*Preparing for the worst is still the best way to avoid it.*

*The funny thing about rainy days, and certain other catastrophies, is that the better prepared you are, the less likely it is that anything will ever happen. So it is with the physicians who look to SVMIC for our unrivaled expertise in risk management. Or, in the unhappy event of a cloudburst, our unparalleled support in the courtroom. With a quarter century of experience as malpractice insurers, we are qualified like no one else could be, when it comes to providing the shelter you'll need, should the worst case scenario ever become more than an unpleasant possibility.*



For more information, contact Randy Meador or Susan Decareaux • P.O. Box 1065 Brentwood, TN 37024-1065  
e-mail: [svmic@svmic.com](mailto:svmic@svmic.com) • Web Site: [www.svmic.com](http://www.svmic.com) • 1-800-342-2239 • (615) 377-1999 • SVMIC is exclusively endorsed  
by the Tennessee Medical Association and its 50 component societies.





**SUCCESS**

**Prestige**

**Fantastic Tax Savings**

**VALETS WILL WORSHIP YOU**

**No Luxury Tax**

**Power**

**Fiser**  
**HUMMER®**

**2001 HUMMERS**  
**In Stock**

**We Want Your Business**  
**1.800.776.4069 • 501.847.9043**  
**[www.fiser.com](http://www.fiser.com)**

**CLEARANCE SALE**

**on 2000 Models**  
2000 Red Soft Top  
2000 Yellow Soft Top  
2000 Green Soft Top  
2000 White Soft Top

**Pre-Owned**

'95 Silver Wagon, Diesel  
'96 Red Soft Top, Diesel  
'98 Green Soft Top, Diesel  
'98 Red Wagon/Tan  
'99 White Soft Top, Diesel  
'99 Red Hard Top/Grey

**Two of the best financial planners in the nation are in Arkansas.**

**They can be found at The Arkansas Financial Group.**

Since 1985, we've been helping busy people make smart financial decisions. So next time you're looking for objective answers to life's crucial financial decisions, call The Arkansas Financial Group. You'll be in great company.

Here's what the editors of *Worth* and *Medical Economics* had to say:

*"The Best 150 Financial Advisers for Doctors, 8/00"*

*"The Best 250 Financial Advisers, 9/99"*

*"The Best 300 Financial Advisers, 9/98"*

*"The Best 250 Financial Advisers, 10/97"*

*"The 120 Best Financial Advisers for Doctors, 7/27/98"*

*"Fee-only, objective, customized, comprehensive, affordable advice"*

**The Arkansas**  
**Financial Group, Inc.**  
**376-9051**



**CINDY CONGER**  
MBA, CPA/PFS, CFP

**RICK ADKINS**  
MBA, CFP, ChFC

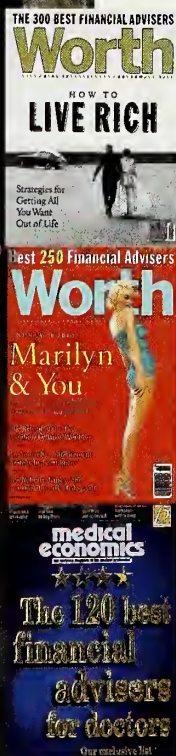


PHOTO: KELLY QUINN/TERRITORIAL RESTORATION

COMMUNICATIONS COORDINATOR  
Judy Hicks

EXECUTIVE VICE PRESIDENT  
Kenneth LaMastus, CAE

ASSISTANT EXECUTIVE VICE PRESIDENT  
David Wroten

EDITORIAL BOARD  
Sue Chambers, MD                      Pediatrics  
Joseph M. Beck, II, MD                Oncology  
Lee Abel, MD                           Internal Medicine  
Samuel Landrum, MD                   Surgery  
Jerry Kendall, MD                      Family Practice  
William Ackerman, MD                Anesthesiology

EDITOR EMERITUS  
Alfred Kahn Jr., MD

ARKANSAS MEDICAL SOCIETY  
2000-2001 OFFICERS

Gerald A. Stolz, Jr., MD, Russellville  
*President*

Joe Stallings, MD, Jonesboro  
*President-elect*

Paul A. Wallick, MD, Monticello  
*Vice President*

Lloyd G. Langston, MD, Pine Bluff  
*Immediate Past President*

Carlton L. Chambers, III, MD, Harrison/Little Rock  
*Secretary*

Dwight M. Williams, MD, Paragould  
*Treasurer*

Anna Redman, MD, Pine Bluff  
*Speaker, House of Delegates*

Kevin Beavers, MD, Russellville  
*Vice Speaker, House of Delegates*

Joseph M. Beck, II, MD, Little Rock  
*Chairman of the Council*

Established 1890. Owned and edited by the Arkansas Medical Society and published under the direction of the Council.

Advertising Information: Contact Stephanie Hopkins, P.O. Box 3686, Little Rock, AR 72203; (501) 372-2816.

Postmaster: Send address changes to: *The Journal of the Arkansas Medical Society*, P. O. Box 55088, Little Rock, Arkansas 72215-5088.

Subscription rate: \$30.00 annually for domestic; \$40.00, foreign. Single issue \$3.00.

The *Journal of the Arkansas Medical Society* (ISSN 0004-1858) is published monthly by the Arkansas Medical Society, #10 Corporate Hill Drive, Suite 300, Little Rock, Arkansas 72205. Printed by The Ovid Bell Press, Inc., Fulton, Missouri 65251. Periodicals postage is paid at Little Rock, Arkansas, and at additional mailing offices.

Articles and advertisements published in *The Journal* are for the interest of its readers and do not represent the official position or endorsement of *The Journal* or the Arkansas Medical Society. *The Journal* reserves the right to make the final decision on all content and advertisements.

Copyright 2001 by the Arkansas Medical Society.

Volume 97 Number 11  
May 2001

# THE Journal

OF THE ARKANSAS MEDICAL SOCIETY

Winner of the ASAE Excellence in Communications Award

## CONTENTS

### 2001 BUSINESS REPORTS

- 367 *Executive Vice President*
- 368 *AMS Council*
- 373 *Nominating Committee*
- 375 *AMS Budget*
- 377 *Long Range Planning Committee*  
*Medical Education Foundation for Arkansas*
- 379 *Arkansas State Medical Board*
- 383 *AMS Benefits*
- 384 *AMS Medical Student Section*
- 385 *Arkansas Health Care Access Foundation*
- 386 *Arkansas Medical Foundation*
- 387 *Arkansas Department of Health*
- 389 *Pulaski County Medical Society*  
*Continuing Medical Education Accreditation Committee*

### DEPARTMENTS

- 366 *What We've Done for You Lately*
- 391 *People + Events*
- 393 *Arkansas Retreats*
- 394 *Index to Advertisers*



# Let Us Hear From You!

You can now e-mail AMS  
at the  
following addresses:

Main address:  
[ams@arkmed.org](mailto:ams@arkmed.org)

Ken LaMastus:  
[klamastus@arkmed.org](mailto:klamastus@arkmed.org)

Lynn Zeno:  
[zeno@arkmed.org](mailto:zeno@arkmed.org)

David Wroten:  
[dwroten@arkmed.org](mailto:dwroten@arkmed.org)

Kay Waldo:  
[kwaldo@arkmed.org](mailto:kwaldo@arkmed.org)

Journal:  
[journal@arkmed.org](mailto:journal@arkmed.org)



Plus. . .

Visit our web site at:  
[www.arkmed.org](http://www.arkmed.org)

## WHAT WE'VE DONE FOR YOU LATELY



## AMS Supports Ban on Smoking in Restaurants

BY DAVID WROTEN

For the last three months, the focus of activity has been at the state Capitol. However, on Thursday, March 15, a lesson in democracy took place in the State Health Department auditorium, where the public spoke out on the proposed ban on smoking in restaurants. Dr. William N. Jones of Little Rock was there to speak for the Arkansas Medical Society.

After two hours of testimony, the count was clear — 25 spoke in favor of the ban, six against. Speaking against the regulation were representatives of the restaurant industry and individual restaurant owners. Speaking for the regulation were grandmothers, a young mother and her infant child, several physicians, an extraordinary number of teen-agers, people whose lives have been impacted by smoking and exposure to second-hand smoke, and YES, even a couple of restaurant owners.

Near the end of the hearing a young man, probably no more than 16 years old, was able to summarize all of the comments he had heard into three words ... rights, money and health.

The restaurant owners spoke of their right to run their businesses the way they wish without government interference and the right of consumers to choose their restaurant. The proponents of the regulation spoke of rights as well — their right to enjoy a meal without smoke blowing in their face, the rights of restaurant employees to work in a smoke-free environment, and the rights of infants and children, who have no choice where their parents take them to eat.

The restaurant owners also talked about money and the financial impact the regulation would have on their business. They assume, of course, that smokers will stay home and no longer eat at restaurants if smoking is banned. However, there are studies on this issue that show that business and profits have actually increased in places where similar regulations have been enacted.

Everyone talked about health. It was clear to anyone listening that health is the overriding issue in this discussion. It trumps both the "rights" issue and the "money" issue. When one chooses to operate a restaurant, they do so knowing that their rights end where the public's health begins. The public expects and demands that health officials regulate eating establishments to protect the safety of the food. Tobacco smoke in those restaurants is no less a threat.

While we may have the option of sitting in "non-smoking" sections, we usually must travel through the smoking section to get there, or even worse, the non-smoking area is separated only by a half-wall or screen. And what of the restaurant employees, particularly the wait staff? How many other employees in America are expected to breathe second-hand smoke while performing their job?

Surely we have reached a point in our understanding of the health consequences of tobacco smoke where the outcome of this issue should be crystal clear. A total ban on smoking in restaurants is the right thing to do.

And for one last reality check. If a smoker can sit through an entire Razorback football or basketball game without a smoke, surely they can last long enough for my children to finish their meal. ■

# Report of the Executive Vice President

BY KEN LAMASTUS, CAE



The AMS  
was  
responsible  
for a  
regulation  
passed by  
the  
Arkansas  
Insurance  
Department  
that will  
help  
physicians  
with slow  
payments  
by  
insurance  
companies  
and some  
third-party  
payers.

**W**e won the tobacco settlement battle — well maybe. After the Arkansas House of Representatives failed to pass the CHART plan in the special legislative session last year, Gov. Mike Huckabee referred the issue to the people through an initiated act with the help of several groups, including the Arkansas Medical Society, which provided more than \$50,000 for the effort.

The people of Arkansas voted overwhelmingly (64%) to approve the plan, but it may not be over with yet. The tobacco money must be appropriated through the Arkansas General Assembly, and there seems to be some disagreement in the House.

The AMS's goal was to see that the recommendations of the Centers for Disease Control and Prevention's for tobacco prevention, control and cessation were adequately funded and to further expand Medicaid to the uninsured. These issues are drawing a great deal of interest, and the question is, "Will the Arkansas General Assembly appropriate the money as voted on by the people of the state or will a portion of this money be used for other purposes?" If all the tobacco money is used for health care, then Arkansas will be the only state in the union to use 100% of its money on health.

The AMS was responsible for a regulation passed by the Arkansas Insurance Department that will help physicians with slow payments by insurance companies and some third-party payers.

David Wroten has worked with the Arkansas Workers' Compensation Commission to help improve their fee schedule. Some time ago, the commission recommended their fee schedule be the same as the Medicare Fee Schedule. The AMS, along with physicians and their staff from across the state, were successful in getting this recommendation overruled. Part of the agreement was that the Workers' Compensation Commission would update their fee schedules periodically.

Dr. Carlton Chambers, who has chaired the AMS's Long Range Planning Committee, has received a lot of help from physicians from across the state to determine ways the Society can be more responsive and helpful. Work in this area is continuing, and we anticipate that recommendations from the three Long Range Ad Hoc Committees (Governance, Member-

ship, and Communication) will be presented to the House of Delegates at the AMS's annual meeting in May.

Some of the recommendations from the Long Range Planning groups have been put in place. Continuing medical education is now offered online to AMS members at a 10% discount, and a bulletin board for the exchange of information between members is available. We ask that you view our Web site, [www.arkmed.org](http://www.arkmed.org).

The AMS has joined the Arkansas Foundation for Medical Care and several health-related associations and licensing boards to form the Arkansas Patient Safety Initiative. This resulted from a very scathing report by the Institute of Medicine concerning mistakes made in medicine. Efforts are being made to determine system changes that could prevent some of the problems now occurring.

The AMS also continues to offer low-cost seminars to physicians and their staff on important issues. The Second Edition of the *Physician's Legal Guide* — a must for any medical office — is available at the AMS office.

We may have a chance of passing some form of the patient protection legislation in Congress. If a reasonable act can be passed, it would remove the ERISA liability exemption and make health plans and insurance companies responsible for their actions the same way doctors and any other form of business is responsible.

An issue that has been on the horizon but has not reached the critical stage in Arkansas is the cost of malpractice insurance. Many states have already faced significant increases. Back in the 1970s, physicians could pass the cost of malpractice insurance on to their patients. With price controls that now exist with Medicare, Medicaid, Workers' Compensation and managed care, it would be virtually impossible for physicians to recoup these increased costs.

The Arkansas State Board of Health recently established regulations to forbid smoking in eating establishments. This has been a goal of the AMS, and we should thank the members of the State Board of Health for their work.

Thanks to our members and staff who continue to work on issues, regulations and legislation of concern to Arkansas physicians and the people they serve. ■



# Report of the Council

The Council of the Arkansas Medical Society met on May 6, 2000; Aug. 2, 2000; Oct. 29, 2000; and Jan. 31, 2001. A brief summary of actions taken follows:

## May 6, 2000

1. David Wroten gave an update on the Arkansas Department of Human Services contract with Arkansas Behavioral Care to provide mental health services to Medicaid patients.
2. Wroten reported that the Arkansas Medical Society would be meeting with representatives of the Arkansas Hospital Association, Arkansas Pharmacy Association, Arkansas Nurses Association, Arkansas Foundation for Medical Care, Arkansas State Medical Board and other organizations to discuss voluntary efforts to reduce medical errors.
3. An update on the Workers' Compensation Fee Schedule was provided by Wroten. The Arkansas Workers' Compensation Commission has increased the fee schedule by 10%.
4. Ken LaMastus encouraged the Council to comply with Medicaid's request to use electronic fund transfers for reimbursement.
5. Dr. Carlton Chambers reported that the AMS had received a four-year re-recognition from the Accreditation Council for Continuing Medical Education. As a recognized accrediting agency, the AMS recognizes institutions in Arkansas to offer educational programs and provide CME credit.
6. Lynn Zeno provided an update on the tobacco settlement negotiations. Upon motion, the Council approved \$25,000 of reserves be used as an initial step to support the initiated act process and review the process as it progresses.
7. The Council approved requests for dues exemption.
8. The following committee appointments were approved by the Council:
  - **Budget Committee:** Brenda Powell, MD, Hot Springs
  - **Journal Editorial Board:** Reappoint Samuel Landrum, MD, Fort Smith, representing general surgery; Joseph Beck, MD, Little Rock, representing oncology; William Ackerman, MD, Little Rock, representing anesthesiology
  - **Medical Education Foundation for Arkansas:** Reappoint Martin Eisele, MD, Hot Springs, President
  - **Pension Plan Committee:** Reappoint John Wilson, MD, Little Rock; Reappoint Samuel Welch, MD, Little Rock
  - **Arkansas Medical Foundation:** Position #1: Jerry Stringfellow, MD, Texarkana
  - **Young Physicians Task Force:** Kimberly Garner, MD, Pine Bluff, Chairman
- **Medical Student Councilor:** Erik Shultz, Little Rock
9. The Membership Report, Budget Report and MEFFA audit were presented for information.
10. The AMS Audit was presented by LaMastus. Upon motion, the Council voted to accept the audit.
11. Dr. J.R. Baker discussed the Arkansas State Medical Board's proposed regulation relating to alcohol and mind altering substances in the actively treating physician.
12. Dr. Harold Wilson discussed an issue with Medicaid and fetal non-stress test. Wroten reported a meeting has been set with the Arkansas Department of Human Services to discuss this issue. The Council directed Wroten to continue discussions with the Arkansas Department of Human Services on these issues.
13. Dr. Jan Turley discussed a recent situation where he had been asked to sign a background verification disclosure and agree to allow a detective agency to investigate his background for a hospital staff application. Upon motion, the Council directed this issue be referred to the Executive Committee for review.
14. Dr. Richard Corlin, AMA Speaker of the House of Delegates, greeted the Council. Dr. Corlin also expressed his concern of the issue regarding an agency investigating a physician's background.

## Aug. 2, 2000

1. Zeno gave an update on federal and state legislative issues.
2. Wroten reported on July 11, 2000, the Arkansas Insurance Department assumed control of American Investors Life Insurance Co. AMS Benefits Inc. is working with clinics insured by American Investors to find other coverage.
3. Wroten also reported on the proposal sent to the Arkansas Insurance Commissioner for a prompt payment regulation.
4. LaMastus reported the AMS would be working with Helus/Intel to provide education on Internet technology. LaMastus also reported plans to improve and update the Society's Web page.
5. Dr. Scott Claycomb of Warren was approved to fill the vacancy in the Fifth Councilor District.
6. A financial report of the 2000 annual meeting was submitted for information. The AMS will return to the Embassy Suites in 2002.
7. Wroten distributed a listing of delinquent and non-members to Council members. He urged them to contact those listed to encourage membership in the AMS.
8. Dr. Carlton Chambers distributed a list of members for three new committees established as a result of the long-

range planning meetings. The three committees will address membership, governance, and communication issues.

9. Dr. William Jones discussed the recent issue addressed at the Arkansas State Board of Health meeting regarding a smoking ban in restaurants.
10. Dr. John Burge reported on the June 2000 AMA meeting. Dr. Michael Moody reported there is a movement under way to redesign the organizational structure of the AMA, allowing for more specialty representation which may diminish state representation.

### **Oct. 29, 2000**

1. John Meador, co-chairman of the Arkansas Conflict Resolution Association Speakers Committee, discussed the association's activities.
2. Dr. Dwight Williams, chairman of the Ad Hoc Committee on Governance, reported on the Oct. 29, 2000, meeting. The committee discussed the structure of the Executive Committee, publishing meeting dates, and how the Nominating Committee members are selected and how it functions. The committee plans to review the House of Delegates, how it functions, how it is representative of membership, and if it should continue. They will also discuss how Council members are elected and a name change for the Council.

Dr. Parthasarathy Vasudevan, chairman of the Ad Hoc Committee on membership, reported the committee had met and would be working to find methods to regain lost members and strengthen physician-to-physician contact. The committee also plans to research easy payment plans for dues.

Dr. Linda McGhee, chairman of the Ad Hoc Committee on communication, reported the committee reviewed the *AMS News Brief* and *The Journal of the Arkansas Medical Society*. They discussed the Web site and will research the possibility of a members-only bulletin board, more use of e-mail and a section for resident and student members.

3. LaMastus discussed a proposed amendment to the AMS 401K Plan that would allow using forfeitures to reduce the employer's contribution. Upon motion, the Council approved the amendment.
4. Wroten reported AMS Benefits Inc. is continuing its work to move clinics insured through American Investors to other carriers.
5. The Council approved Dr. Sue Chambers of Little Rock to fill the pediatric position on *The Journal* Editorial Board effective Jan. 1, 2001. Dr. Jerry Byrum has resigned as of year-end 2000.
6. Dr. Carlton Chambers recognized Dr. Steve Strode for his outstanding work on the AMS CME Accreditation Committee.
7. Zeno gave an update on the tobacco settlement for Arkansas. Dr. William Jones encouraged the Council to ask the Arkansas State Board of Health to enact a total ban on smoking in restaurants.
8. The membership report was presented for information.

### **Jan. 31, 2001**

1. Dr. John Burge reported on the AMA Interim Meeting held in Orlando, Fla., Dec. 3-6, 2000. Upon motion, the Council approved a letter be written to the congressional delegation expressing concern about possible profiteering and the shortage of the flu vaccine. Dr. Moody suggested a letter also be sent to the Senate Aging Committee.
2. Dr. Dwight Williams gave a report on the Ad Hoc Committee on Governance. The Governance Committee plans to propose a new framework of governance that will include renaming the Council the Board of Directors.
3. Dr. Gerald Stolz, President of the Arkansas Medical Society, presented a plaque to Dr. I. Dodd Wilson for his service as Dean of the University of Arkansas College of Medicine.
4. Dr. Parthasarathy Vasudevan reported the Ad Hoc Committee on Membership has met several

times and has also suggested that regional meetings be held throughout the state and include social functions inviting non-members and spouses.

5. The Coalition for a Healthier Arkansas Today (CHART) has requested \$2,500 from the Arkansas Medical Society to help with the legal fees in defending the Initiative Act Campaign in getting the CHART plan placed on the November 2000 General Election ballot. Upon motion, the Council approved the expense.
6. LaMastus reported on a recent meeting of the Ad Hoc Committee to establish minimum standards necessary for doctor/patient contact before a physician can prescribe medication. The committee has made a recommendation to the Arkansas State Medical Board that physicians should not practice medicine or prescribe unless a physician/patient relationship has been established.
7. LaMastus reported the AMS ended the year 2000 with income of approximately \$124,000. This was \$24,500 better than budgeted. The Arkansas Medical Society Building ended the year with a \$17,000 profit.
8. Dr. James Kolb, Chairman of the Annual Session Committee, updated the Council on the plans for the Arkansas Medical Society annual meeting to be held May 4-5 at the Arlington Hotel in Hot Springs.
9. LaMastus informed the Council that work is under way to redesign the AMS Web site. This will include adding a "members-only" section.
10. Wroten updated the Council on HIPAA.
11. Wroten reported the AMS and Medicaid have been discussing a modest increase in physician fees. Wroten provided information to the Council on this proposal and asked for feedback within the next week.



# SERVING ARKANSAS' HEALTHCARE INDUSTRY

**WHEN YOUR INSURANCE NEEDS ARE UNIQUE,  
YOU WANT AN AGENT AND INSURANCE  
COMPANY THAT THINK LIKE YOU DO—  
INDEPENDENTLY**

Let's face it: not every insurance company will have the right insurance choices for the unique needs of the health care industry in Arkansas.

Hoffman-Henry doesn't work for any insurance company. We work for you. And our obligation is to help you find the right policy for your needs. From the right company. At the right price.

When it comes to independent thinking for the Arkansas medical community, we recommend St. Paul Fire and Marine Insurance Company. They specialize in the health care industry and will work closely with us to meet your unique insurance needs.

Call one of our three locations for a free review and consultation- *before* your current coverages expire.



**It pays to make the independent choice.**

Little Rock 501-224-8884 • Pine Bluff 870-534-4532 • Searcy 501-268-3528

*Hoffman-Henry is an endorsed insurance provider for members of the Arkansas Medical Society.*

**TheStPaul**

The Executive Committee of the Arkansas Medical Society met on May 24, 2000; June 28, 2000; Aug. 23, 2000; Sept. 27, 2000; and Dec. 21, 2000. A brief summary of actions taken follows:

## May 24, 2000

1. Dr. William Sturner, medical examiner for the state of Arkansas, met with the Executive Committee concerning proposed legislation pertaining to the Medical Examiner's Office.
2. The Executive Committee discussed the Arkansas State Medical Board's proposed regulation pertaining to the use of alcohol and mind altering drugs while a physician is on call.
3. Dr. Carlton Chambers discussed the Long Range Planning Committee.
4. Wroten gave an update on the tobacco settlement negotiations.
5. Wroten reported on problems with American Investors Life Insurance Co. This is the company that provides insurance coverage for our group plan.
6. The Executive Committee approved a list of physicians who have requested direct membership in the AMS.

## June 28, 2000

1. Zeno gave an update on the tobacco settlement.
2. The Executive Committee discussed the Nathan Davis Award Dinner to be held in Washington, D.C.
3. Spike Dietrich, a representative from Helus, explained the computer systems they are installing in northwest Arkansas. Helus has asked the AMS to endorse their system.
4. Dates and accommodations for future Arkansas Medical Society meetings were discussed. The Arlington Hotel is the only hotel available that is large enough to accommodate the AMS annual meeting next year.
5. The Executive Committee ap-

**The one thing missing  
is you.**

**pro travel**  
"SPECIALISTS FOR PROFESSIONALS"

8201 Ranch Boulevard - Building B - Suite 5  
Little Rock, AR 72212 - 501-868-9959 - 800-713-0037



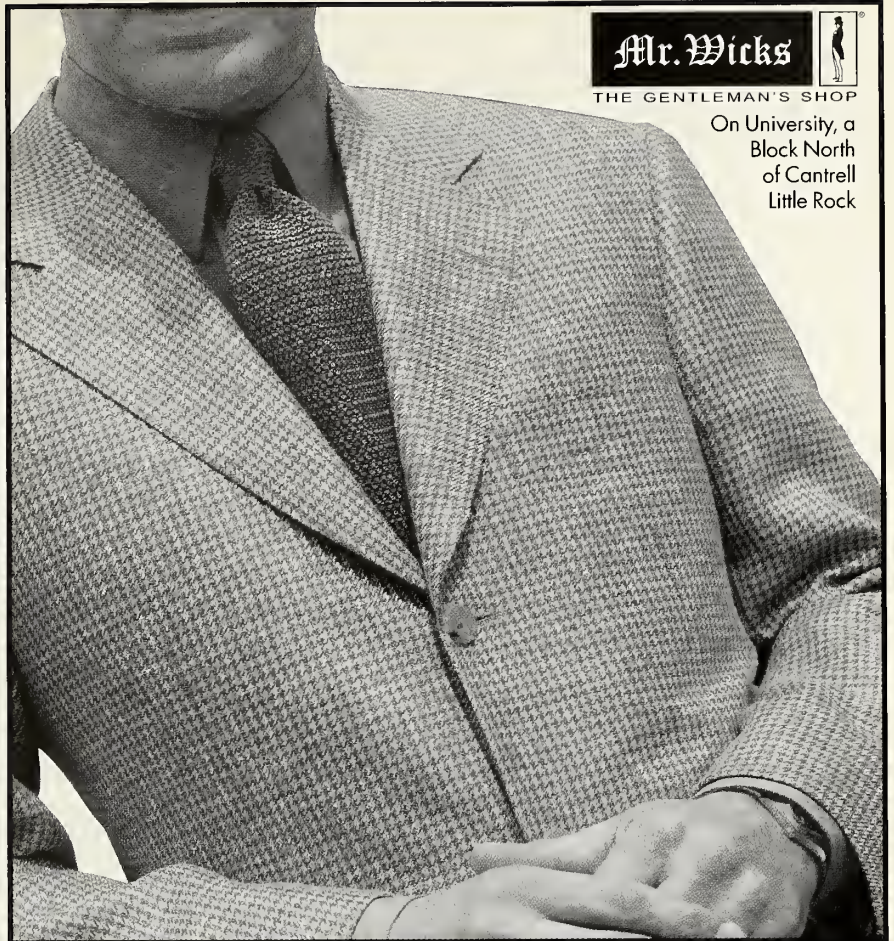
proved requests for direct and emeritus membership.

### Aug. 23, 2000

1. The Executive Committee discussed a survey from the AMA concerning their Commission on Unity.
2. Wroten gave an update on the tobacco settlement. Another \$25,000 request from the governor has been approved for use in getting the initiative on the November ballot.
3. Wroten discussed the Arkansas Insurance Department's regulation on prompt payment.
4. The Executive Committee discussed a letter concerning moving a monument from MacArthur Park to the University of Arkansas for Medical Sciences campus.
5. The Executive Committee approved requests for emeritus and direct memberships in the AMS.
6. The Executive Committee reviewed a press release regarding John P. Shock, MD, being appointed interim dean of the University of Arkansas College of Medicine. The Executive Committee suggested that Dr. Shock be invited to attend Council meetings.

### Sept. 27, 2000

1. Kay Waldo reported to the Executive Committee information about the cost and requirements hotels are placing on those doing convention business with them.
2. Wroten discussed quality of health care issues comparing Arkansas to other states.
3. Wroten reported on a recent meeting with the dean of the School of Nursing at UAMS.
4. The Executive Committee reviewed the Arkansas State Medical Board's proposed regulation regarding standards for prescribing legend medication.
5. The Executive Committee also reviewed the Arkansas State Medical Board's proposed regulation pertaining to licensure of physicians from other states and Canada.



**Mr. Wicks**

THE GENTLEMAN'S SHOP

On University, a  
Block North  
of Cantrell  
Little Rock

## Family Practice Opportunity

A Central Arkansas Hospital is seeking a qualified BC/BE Family Practice or Internal Medicine physician to help establish a primary care clinic in a rapidly growing area of Central Arkansas, minutes from Little Rock. The physician will be required to relocate to this bedroom community.

The selected candidate will be the sole physician in the community and will be an instant success. The physician will have a predominately outpatient office practice and Hospitalists are available for inpatient care. Employment is an option.

Qualified candidates should submit their information and CV to the email address below.

- Instant Success
- Bedroom Community
- Minutes from Little Rock
- Solo Practice
- Start-up clinic
- Primarily Outpatient
- Hospitalists Available
- Must Relocate
- Employment Options

*All Contacts are kept Confidential!*

E-mail Information and Resumes to:  
[jclawren@aol.com](mailto:jclawren@aol.com)



# Medical Practice Consultants, Inc.

An Arkansas-Based Firm with Over 75 Years  
of Medical Practice Knowledge

- Custom-Designed Compliance Program
- Coding and Documentation Evaluations
- Practice Assessments With Reports

Call 1-870-236-1899

for information on affordable services  
designed to meet YOUR medical practice needs

**M P C**

Donald B. Smith	— CEO
Benjamin "Mac" Butler	— Consultant
Patty Pendergrast	— Consultant

6. LaMastus presented a one-page summary of additions and deductions from AMS reserves over the last few years.
7. The Executive Committee approved a list of physicians requesting direct membership in the AMS.
8. The Executive Committee recommended a letter be written to compliment Dr. Charles Kemp for his contribution not only in medicine, but also to his community at large.
9. The Executive Committee reviewed updated information on the marker in MacArthur Park and suggested the dean at UAMS be contacted for his thoughts as to where the marker should be relocated.

**Dec. 21, 2000**

1. LaMastus indicated he had sent out a memorandum last Friday asking members of the Council if they had any interest in being nominated for the Emerging Leaders Development Program to be held in conjunction with the AMA's National Leadership Conference. The Executive Committee suggested that Dr. Hugh Jackson be recommended for the Emerging Leaders Development Program.
2. Dr. Carlton Chambers mentioned his concern regarding the efforts in trying to get support for their legislation in January. The Executive Committee suggested the AMS staff make contact to quietly express our concern with the legislation.
3. LaMastus discussed a letter he had received from the Arkansas State Medical Board requesting the AMS meet with their attorney to help draft legislation to establish minimum standards necessary for a physician/patient contact before a physician prescribes medication. The Executive Committee authorized AMS staff to attend these meetings. ■

## Three New Ways To Make Your Referrals To UAMS Easier

- 1. Log on to <http://physicianlink.uams.edu>.
- 2. Use the new exclusive referring physician toll free appointment line, 1-866-UAMSDOC (826-7362).
- 3. Stop by our booth at the Arkansas Medical Society's Annual Meeting and learn more.



Where Knowledge Creates  
Better Medicine

Physician Referral Office • 4301 West Markham, Slot 727  
Little Rock, AR 72205 • 501/686-8206

# Report of the Nominating Committee


By ANTHONY HUI, MD, CHAIRMAN

The members of the 2000/2001 Nominating Committee are Drs. Leonus Shedd; J.R. Baker; Marion McDaniel; David Jacks; Donya Watson; Michael Young; Timothy Webb; Timothy Waack; C. Reid Henry Jr., secretary; and Anthony Hui, chairman. The Nominating Committee would like to present to the Society the following nominees:

**President-elect:** Carlton Chambers, MD, Little Rock  
**Vice President:** Reappoint Paul Wallick, MD, Monticello  
**Treasurer:** Reappoint Dwight Williams, MD, Paragould  
**Secretary:** Brenda Powell, MD, Hot Springs  
**Vice Speaker of the House:** James Wharton, MD, Springdale  
**Delegate to the AMA:** Reappoint Larry Lawson, MD, Paragould  
**Alternate Delegate to the AMA:** Reappoint Michael Moody, MD, Salem

## District Councilors:

**District 1:** Reappoint Scott Ferguson, MD, West Memphis  
**District 2:** William Waldrup, MD, Batesville  
**District 3:** Reappoint Dennis Yelvington, MD, Stuttgart  
**District 4:** Reappoint John Lytle, MD, Pine Bluff  
**District 5:** Reappoint William Dedman, MD, Camden  
**District 6:** Reappoint Michael Young, MD, Prescott  
**District 8:** Appoint David Bourne, MD, Little Rock; appoint Stephen Magie, MD, Little Rock; reappoint Joseph Beck, MD, Little Rock; reappoint C. Reid Henry Jr., MD, Little Rock; reappoint Anthony Johnson, MD, Little Rock; reappoint Samuel Welch, MD, Little Rock  
**District 9:** Reappoint Anthony Hui, MD, Fayetteville; reappoint Jan Turley, MD, Rogers  
**District 10:** Reappoint Robert Sanders, DO, Fort Smith; reappoint Mike Berumen, MD, Fort Smith  
**Medical Student Councilor:** Dwight Johnson, Little Rock ■




*Introducing the*

**DIAMOND STAR**

**Fast: 147 Knots / 169 MPH**

**Affordable: Ownership from 25% to 100%**

**And Fun!!!**

 **CENTRAL**  
FLYING SERVICE

Call Bob Rollins  
501-975-9394

 **SKYSHARE**

Buy — Sell  
Lease — Rent



The Med-Plus Group is a B2B website that helps medical facilities find the best prices available on New, Used, and Refurbished medical equipment. With over 500 dealers, suppliers and manufacturers to select from, we have the solutions to meet your needs. In addition, we offer our customers flexible lease options to finance their purchase. Visit us on-line today or call Mike South or Rick Wooldridge for more information.



**MedPlusQuotes**

Healthcare Resources

(800) 643-0944 Fax (501) 224-0930  
www.medplusquotes.com  
email: JRW@medplusquotes.com  
MLS@medplusquotes.com



# Arkansas Medical Society Insurance Programs....



## AMS BENEFITS, INC.

A wholly owned subsidiary of the  
Arkansas Medical Society

P.O. Box 55088

Little Rock, Arkansas 72215-5088

(501)224-8967

WATS 1-800-542-1058

FAX (501) 224-6489

"Available products include group  
health, office package, professional  
liability, home, auto, and more."

*tailor-made for physicians*

Insurance products are a fact of life. You can buy them almost anywhere. Fortunately there's one agency that only represents physicians...Arkansas physicians. AMS Benefits, with products to meet both your professional and personal needs.

Call us at 1-800-542-1058 or 501-224-8967

# Cash Budget Report

## *Arkansas Medical Society*

### INCOME

Dues .....	\$696,053
Journal and Directory .....	\$11,000
Booth .....	\$25,000
Annual Session .....	\$32,000
AMA Reimbursement .....	\$9,100
Label and Miscellaneous .....	\$7,400
Interest Income .....	\$87,000
Specialty Desk .....	\$9,020
Continuing Medical Education .....	\$13,000
Allocation of G.A. Department .....	\$5,000
Educational Programs .....	\$45,000
Legal Guide .....	\$2,000
<b>TOTAL</b>	<b>\$941,573</b>

### EXPENSE

Salaries .....	\$322,293
Travel and Convention .....	\$40,000
AMA Delegation .....	\$30,000
President's Account .....	\$5,000
Taxes .....	\$31,000
Retirement .....	\$37,700
Stationery and Printing .....	\$18,000
Office Supplies and Expenses .....	\$37,000
Telephone .....	\$10,000

Rent .....	\$54,672
Postage and Communications .....	\$25,000
Insurance & Bonds .....	\$58,000
Auditing .....	\$5,275
Council and Executive Committee .....	\$4,000
Journal and Directory Expense .....	\$12,000
Dues and Subscriptions .....	\$8,000
Gifts and Contributions .....	\$2,500
Alliance .....	\$8,700
Legal Services (retainer) .....	\$27,450
Committee/District Meeting/LRP .....	\$5,000
Public Relations .....	\$3,000
Miscellaneous Expenses .....	\$5,000
Office Equipment & Furniture .....	\$9,000
Continuing Medical Education .....	\$12,000
Contract Labor .....	\$5,000
AMS Resident & Student Section .....	\$8,500
Annual Session .....	\$67,000
Educational Programs .....	\$24,000
Physicians Health Committee .....	\$10,000
MEFFA — Dues .....	\$11,600
Legal Guide .....	\$1,000
<b>TOTAL</b>	<b>\$897,690</b>

## *Governmental Affairs Department*

### INCOME

Dues .....	\$233,575
Income — Misc. Projects .....	\$6,000
<b>TOTAL</b>	<b>\$239,575</b>

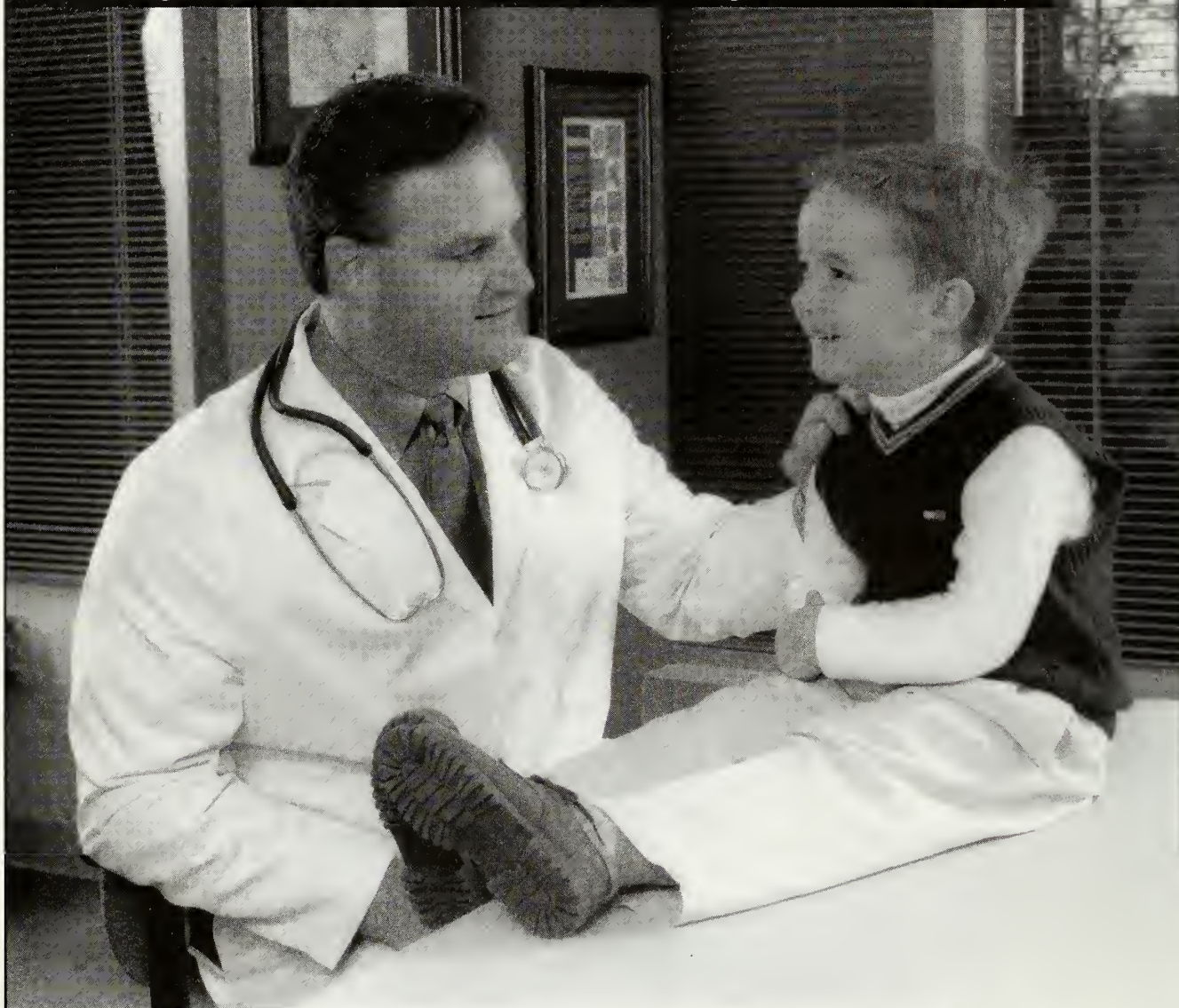
### EXPENSE

Salaries .....	\$137,347
Retirement .....	\$15,300
Taxes .....	\$9,700
Stationery and Printing .....	\$4,000

Office Supplies, Telephone, Misc. ....	\$7,300
Equipment and Furniture .....	\$1,500
Auto, Travel and Meeting .....	\$50,000
Legal Retainer .....	\$18,800
Postage and Communications .....	\$16,000
Insurance and Bonds .....	\$9,100
Office Allocation To AMS .....	\$5,000
Audit GA .....	\$1,500
<b>TOTAL</b>	<b>\$275,547</b>



# Putting the *Care* back in Managed HealthCare



You have a choice about your healthcare plan.  
That's why we've put the *care* back in managed healthcare.

We're Arkansas Managed Care Organization (AMCO) — Arkansas people working to take care of your health. AMCO is a recognized leader in managed healthcare in the state, not only because of our size, but also for our high degree of accountability, outstanding customer service and stability.

Our statewide PPO network offers community care through:

- More than 3,800 physicians and hundreds of other healthcare professionals;
- Services in over 100 hospitals; and,
- An excellent staff representing your best interests.



*Serving employers and their greatest  
asset with quality managed care.*

Call us today at  
**1-800-278-8470 or 501-225-8470.**

#10 Corporate Hill Drive, Suite 200  
Little Rock, Arkansas 72205  
[www.amcoppo.com](http://www.amcoppo.com)



# Report of the Long-Range Planning Committee

BY CARLTON CHAMBERS, MD, CHAIRMAN

In 1999, a steering committee was appointed to guide the Arkansas Medical Society through a long-range planning process. The results of that process were presented at the May 2000 House of Delegates meeting held at the Embassy Suites in Little Rock. The plan was approved with the following goals: provide leadership in developing health care policy; increase member involvement in AMS programs and activities; improve the organizational strength of the AMS; strengthen the role of AMS as an advocate for physicians and patients; position the AMS as the leader in providing information, education and assistance to members; and produce a 15% increase in membership by 2003.

Three subcommittees have been established to help the AMS reach these goals: Membership, Governance, and Communications. The committee chairs

are Parthasarathy Vasudevan, MD, Membership; Linda McGhee, MD, Communication; and Dwight Williams, MD, Governance. These committees were challenged to accomplish the following tasks.

**Governance** — Review the strengths and weaknesses of the AMS organizational structure and, if needed, recommend changes to ensure broad representation, meaningful participation, continuity of leadership and efficient conduct of business.

**Communications** — Investigate and recommend improved communications strategies including a review of AMS publications and use of Internet-based technology and exploration of the development of a public relations plan to promote the AMS and its members' contributions to health care in Arkansas.

**Membership** — To develop an effective physician-to-physician contact

system for recruiting and retaining members and assist the AMS staff in identifying effective strategies to strengthen the bond between physicians and the AMS.

These committees are still open and welcoming input from membership. Please contact the committee chairpersons with your ideas and desires. The status of activities and efforts will be reported at the May 2001 House of Delegates meeting.

The time and effort extended on behalf of the membership by the fact-finding committee cannot be measured. These groups receive my utmost appreciation and gratitude. I especially thank the three committee chairpersons and their members who are working on our behalf so AMS can continue to respond to the changing professional and economic environment faced by physicians in today's world. ■

## Medical Education Foundation for Arkansas Report

BY MARTIN EISELE, MD, PRESIDENT

The Medical Education Foundation for Arkansas was organized by the Arkansas Medical Society in 1959. Members of the board are Drs. William Bishop, Little Rock; James Kyser, Little Rock; Jan Turley, Rogers; and Steve Shrum, Medical Student Representative. Serving as ex-officio with voting power are the AMS president, president-elect, immediate past president and the dean of the University of Arkansas College of Medicine.

The Foundation receives funds contributed by the AMS that amounts to \$5 for each full dues-paying member per year. Since MEFFA is a tax-exempt foundation (501(c)(3)), all contributions are tax deductible. The Foundation has an independent audit each year, and a copy

of the audit is provided to the Council. Funds are used each year to promote the art and science of medicine and the betterment of the health of the public by providing financial support to recognize schools or institutions that provide primary and advanced medical education.

A portion of MEFFA funds is held by the Arkansas Community Foundation. Funds from the Arkansas Community Foundation are expended only upon the recommendation of the MEFFA board. The board approved the following expenditures for 2000:

- \$8,000 to continue the Distinguished Lecture Series (10 speakers at \$800 each) at UAMS.
- \$10,500 to purchase 525 AMS *Physician Legal Guides* at \$20 each for residents to

use in the new Core Curriculum Series.

- \$2,000 to purchase a new computer for the department of psychiatry.
- \$2,700 to purchase a Welch Allyn Electronic Stethoscope.
- \$5,289 to purchase a computer and CD tower for the department of pediatrics.
- \$5,000 contribution to the Ben Saltzman Chair on Primary Care. MEFFA has contributed a total of \$25,000 to this chair.

The MEFFA Board also requested Ken LaMastus draft changes to the bylaws to include a medical student on the board. Medical student representatives must be a member of the American Medical Association and the AMS, a third-year medical student and the president of the Medical Student Section or their designee. ■



# Has finding the right injectables become a pain in the rear?

LEE PHARMACY CAN GIVE YOUR OFFICE A REAL SHOT IN THE ARM WHEN IT COMES TO OBTAINING THOSE HARD-TO-FIND PRODUCTS.

WE OFFER A COMPLETE LINE OF COMPOUNDING SERVICES INCLUDING INJECTABLES, OPHTHALMICS, TOPICALS, RECTAL AND ORAL MEDICATIONS.



OUR INJECTABLES ARE TESTED BY AN INDEPENDENT LABORATORY FOR POTENCY, PYROGENS AND STERILITY ACCORDING TO THE UNITED STATES PHARMACOPOEIA'S STANDARDS.

CALL OR VISIT OUR WEBSITE FOR ADDITIONAL INFORMATION.



**LEE PHARMACY**  
AND COMPOUNDING CENTER

1.877.285.3379 • [WWW.LEERX.COM](http://WWW.LEERX.COM)

**Easter Seals**

**delta  
project**

Helping children and families in Arkansas' Delta communities reach their maximum potential by enhancing their health, development and education.

Easter Seals Delta Project works with local healthcare providers, educators and agencies to provide services for children diagnosed with or at risk for developmental delays. For more information, contact Easter Seals at 1.877.533.3600.



*Creating solutions, changing lives.*



# Arkansas State Medical Board 2000 Annual Report

The 2000 members and officers of the Arkansas State Medical Board are as follows:

W. Ray Jouett, MD, Chairman; Warren M. Douglas, MD, Vice-Chairman; Alonzo D. Williams Sr., MD, Secretary; John B. Currie Sr., Treasurer; J.R. Baker, MD; John E. Bell, MD; Sue R. Chambers, MD; Bobby H.

Dennis; David C. Jacks, MD; Trent P. Pierce, MD; Orman W. Simmons, MD; C.E. Tommey, MD; and James E. Zini, DO.

The Board met bimonthly and addressed complaints, hearings, and other pertinent business affecting health care in the state of Arkansas.

## 2000 Licensing Statistics

	Newly Licensed	Total
Medical Doctors and Doctors of Osteopathy .....	381	7,852
Medical Doctors and Doctors of Osteopathy (in state) .		5,034
Occupational Therapists .....	91	793
Occupational Therapist Assistants .....	0	120
Physician Assistants .....	13	45
Respiratory-Care Therapists .....	109	1,251

## Summary of Board Proceedings for 2000

Individual Complaints and Discussions (total) .....	290
Complaints (including investigations) .....	175
Discussions .....	115

## Complaints (including investigations)

Advertising .....	6
Alcohol/Drugs .....	12
Billing Discrepancies .....	10
Communication or Dr./Patient Conflict .....	15
Data Bank Report .....	1
Emergency Room Treatment .....	3
Ethics .....	5
Investigation .....	31

Office Personnel .....	6
Falsifying Information .....	3
Failure to Release Medical Records .....	2
Miscellaneous .....	17
Negligence .....	15
Practicing/Allowing to Practice without a License .....	5
Overcharging .....	1
Overprescribing .....	10
Overtesting .....	0
Actions Taken by Other States .....	4
Lack of Physician Response .....	13
Quality of Care Issue .....	51
Record-Keeping .....	0
Self-Prescribing .....	0
Sexual Harassment .....	2
Unprofessional Conduct .....	9
Unauthorized Prescribing .....	3

## 2000 Board Actions

Probation .....	2
Suspension .....	9
Suspension (stayed) .....	0
Revocation .....	5
Revocation (stayed) .....	3
Surrendered .....	1

# Regulations Passed by the Board and/or Amended During 2000

## Regulation No. 10, Section 3.3

### Regulations Governing the Licensing and Practice of Respiratory-Care Practitioners

**3.3 TEMPORARY LICENSE.** The secretary of the board may issue a temporary permit without examination to practice respiratory care to persons who are not licensed in other states but otherwise meet the qualifications for licensure set out in the act. The temporary permit may be renewable at six (6) month intervals not to exceed a maximum of two (2) permits per applicant. A temporary

permit will be issued to respiratory-care students based on the following criteria: a.) Students must be enrolled in an AMA approved Respiratory-Care program as specified in Section 7.4, entering their last semester of technical training. b.) Students must submit a notarized copy of their current school transcript and a letter of recommendation that states the expected graduation date from their program director. c.) Students will practice limited respiratory care under the supervision of a licensed respiratory-care practitioner, as specified in Section 7.2 and 7.3.

**History:** Adopted May 25, 1988; Amended Sept. 8, 1995, Dec. 4, 1997; Revised March 5, 1999; Amended Feb. 3, 2000



## Regulation No. 24

### Rules Governing Physician Assistants

1. A physician assistant must possess a license issued by the Arkansas State Medical Board prior to engaging in such occupation.
2. To obtain a license from the Arkansas State Medical Board, the physician assistant must do the following:
  - a. Answer all questions to include the providing of all documentation requested on an application form as provided by the Arkansas State Medical Board;
  - b. Pay the required fee for licensure as delineated elsewhere in this regulation;
  - c. Provide proof of successful completion of Physician Assistant National Certifying Examination, as administered by the National Commission on Certification of Physician Assistants;
  - d. Certify and provide such documentation, as the Arkansas State Medical Board should require that the applicant is mentally and physically able to engage safely in the role as a physician assistant;
  - e. Certify that the applicant is not under any current discipline, revocation, suspension or probation or investigation from any other licensing board;
  - f. Provide letters of recommendation as to good moral character and quality of practice history;
  - g. The applicant should be at least 21 years of age;
  - h. Show proof of graduation with a bachelor's degree from an accredited college or university or prior service as a military corpsman;
  - i. Provide proof of graduation of a physician assistant education program recognized by the Committee on Allied Health Education and Accreditation or the Commission on Accreditation of Allied Health Education Programs;
  - j. Show successful completion of the Jurisprudence examination as administered by the Arkansas State Medical Board covering the statutes and Rules and Regulations of the Medical Board, the Arkansas Medical Practices Act, the Physician Assistant Act and the laws and rules governing the writing of prescriptions for legend drugs and scheduled medication;
  - k. The submission and approval by the Board of a protocol delineating the scope of practice that the physician assistant will engage in, the program of evaluation and supervision by the supervising physician;
  - l. The receipt and approval by the Arkansas State Medical Board of the supervising physician for the physician assistant on such forms as issued by the Arkansas State Medical Board;
  - m. Provide proof of medical liability insurance.
3. If an applicant for a license submits all the required information, complies with all the requirements in paragraph 2, except paragraph 2 (k), and the same is reviewed and approved by the Board, then the applicant may request a Letter of Intent from the Board, and the Board may issue the same. Said Letter of Intent from the Board will state that the applicant has complied with all licensure requirements of the Board except the submission of a protocol and supervising physician and that upon those being submitted and approved by the Board, it is the intent of the Board to license the applicant as a physician assistant.
4. The Protocol.
  - a. This protocol is to be completed and signed by the physician assistant and his designated supervising physician. Said protocol will be written in the form issued by the Arkansas State Medical Board. Said protocol must be accepted and approved by the Arkansas State Medical Board prior to licensure of the physician assistant.
  - b. Any change in protocol will be submitted to the Board and approved by the Board prior to any change in the protocol being enacted by the physician assistant.
  - c. The protocol form provided by the Board and as completed by the physician assistant and the supervising physician will include the following:
    - (1) area or type of practice;
    - (2) location of practice;
    - (3) geographic range of supervising physician;
    - (4) the type and frequency of supervision by the supervising physician;
    - (5) the process of evaluation by the supervising physician;
    - (6) the name of the supervising physician;
    - (7) the qualifications of the supervising physician in the area or type of practice that the physician assistant will be functioning in;
    - (8) the type of drug-prescribing authorization delegated to the physician assistant by the supervising physician;
    - (9) the name of the backup supervising physicians and a description of when the backup supervising physician will be utilized.
5. a. A physician assistant must be authorized by his supervising physician to prescribe legend drugs and scheduled medication for patients. Said authorization must be stated in the protocol submitted by the physician assistant to the Board and approved by the Board. A supervising physician may only authorize a physician assistant to prescribe schedule medication that the physician is authorized to prescribe.

A physician assistant may only be authorized to prescribe schedule III through V medications. The physician assistant will write prescriptions for scheduled medications by utilizing a triplicate prescription form, with the original going to the patient and the pharmacist, a copy being placed in the chart of the patient and a second copy being sent to the Board on a quarterly basis.

- The requirement of writing triplicate prescriptions and forwarding a copy to the Board may be waived by the Board after a period of supervised monitoring by the Board. A physician assistant may not utilize telephone-prescribing authority when prescribing scheduled medications III through V. Prescriptions written by a physician assistant must contain the name of the supervising physician on the prescription.
- b. The physician assistant will make an entry in the patient chart noting the name of the medication, the strength, the dosage, the quantity prescribed, the directions and the number of refills, together with the signature of the physician assistant and the printed name of the supervising physician for every prescription written for a patient by the physician assistant.
  - c. The supervising physician shall be identified on all prescriptions and orders of the patient in the patient chart if issued by a physician assistant.
6. A supervising physician should be available for immediate telephone contact with the physician assistant any time the physician assistant is rendering services to the public. A supervising physician must be able to reach the location of where the physician assistant is rendering services to the patients within one hour.
  7.
    - a. The supervising physician for a physician assistant must fill out a form provided by the Board prior to his becoming a supervising physician. Said supervising physician must provide to the Board his name, business address, licensure, his qualifications in the field of practice in which the physician assistant will be practicing, and the name(s) of the physician assistant(s) he intends to supervise.
    - b. The supervising physician must submit to the Board a notarized letter stating that they have read the regulations governing physician assistant and will abide by them and that they understand that they take full responsibility for the actions of the physician assistant while that physician assistant is under their supervision.
    - c. Backup or alternating supervising physicians must adhere to the same statutory and regulatory rules as the primary supervising physician.
  8.
    - a. Physician assistants provide medical services to patients in a pre-approved area of medicine. Physician assistants will have to provide medical services to the patients consistent with the standards that a licensed physician would provide to a patient. As such, the physician assistant must comply with the standards of medical care of a licensed physician as stated in the Medical Practices Act, the Rules and Regulations of the Board, and the Orders of the Arkansas State Medical Board. A violation of said standards can result in the revocation or suspension of the license when ordered by the Board after disciplinary charges are brought.
  - b. A physician assistant must clearly identify himself or herself to the patient by displaying an appropriate designation; that is, a badge nameplate with the words "physician assistant" appearing thereon.
  - c. A physician assistant will not receive directly from a patient or an insurance provider of a patient any monies for the services he or she renders the patient. Payment of any bills or fees for labor performed by the physician assistant will be paid to the employer of the physician assistant and not directly to the physician assistant.
  9. The supervising physician is liable for the acts of a physician assistant whom he or she is supervising if said acts of the physician assistant arise out of the powers granted the physician assistant by the supervising physician. The supervising physician may have charges brought against him by the Arkansas State Medical Board and receive sanctions if the physician assistant should violate the standards of medical practice as set forth in the Medical Practices Act, the Rules and Regulations of the Board, and the standards of the medical community.
  10. Continuing Medical Education:
    - a. A physician assistant who holds an active license to practice in the state of Arkansas shall complete 20 credit hours per year continuing medical education.
    - b. If a person holding an active license as a physician assistant in this state fails to meet the foregoing requirement because of illness, military service, medical or religious missionary activity, residence in a foreign country, or other extenuating circumstances, the Board upon appropriate written application may grant an extension of time to complete the same on an individual basis.
    - c. Each year, with the application for renewal of an active license as a physician assistant in this state, the Board will include a form which requires the person holding the license to certify by signature, under penalty of perjury, and discipline by the Board, that he or she has met the stipulating continuing medical education requirements. In addition, the Board may randomly require physician assistants submitting such a certification to demonstrate, prior to renewal of license, satisfaction of continuing medical education requirements stated in his or her certification.
    - d. Continuing medical education records must be kept by the licensee in an orderly manner. All records relative to continuing medical education must be maintained by the licensee for at least three years from the end of the reporting period. The records



or copies of the forms must be provided or made available to the Arkansas State Medical Board.

- e. Failure to complete continuing education hours as required or failure to be able to produce records reflecting that one has completed the required minimum medical education hours shall be a violation and may result in the licensee having his license suspended and/or revoked.

**History:** *Adopted Feb. 3, 2000*

## **Regulation No. 25**

### **Centralized Credentials Verification Service Advisory Committee Guidelines**

1. **PURPOSE.** The Centralized Credentials Verification Advisory Committee (CCVSAC) is established in accordance with Act 1410 of 1999 for the purpose of providing assistance to the Arkansas State Medical Board in operating a credentialing service to be used by credentialing organizations and health care professionals. The CCVSAC shall advocate the system throughout the state and work with customers to identify opportunities to improve the system.
2. **MEMBERSHIP.** The CCVSAC will consist of ten (10) standing members who are recommended by the CCVSAC and appointed by the Arkansas State Medical Board, at least six (6) of which shall be representatives of credentialing organizations which must comply with Act 1410. Of these six (6) members, at least two (2) shall be representatives of licensed Arkansas hospitals and at least two (2) shall be representatives of insurers or health-maintenance organizations. The term of each member shall be annual, and members may serve consecutive terms. Ad hoc members will be appointed as necessary by the CCVSAC. Committee members will complete and file with the secretary a conflict of interest disclosure statement annually. This statement will be retained in the permanent records of the CCVSAC.
3. **OFFICERS.** The Arkansas State Medical Board will appoint the Chairman of the CCVSAC. The CCVSAC will elect a vice-chairman and any other officers or work groups desired. CCVSAC meetings will be staffed by Arkansas State Medical Board personnel.
4. **MEETINGS.** Meetings of the CCVSAC will be held on a quarterly basis, or more frequently if needed. CCVSAC members will be notified of changes in operations of the credentials verification service between meetings. CCVSAC members will be consulted or informed of major operational changes before such changes are implemented.
5. **POLICIES.** It is the intent of the Arkansas State Medical Board to provide the CCVSAC maximum input into policies concerning the operation of the

credentialing verification service. Policies will be developed and adopted concerning:

- a. Fees to be charged for use of the service. Fees will be based on costs of operating the service, and the costs shall be shared pursuant to Act 1410.
- b. Availability of the service. Availability includes time required to gain access, time allowed in the system, and geographic availability.
- c. Accessibility and security of the service
  1. Release of information from physicians.
  2. Approval for users to gain access.
  3. Password identification requirements.
- d. Audit privileges for records maintained by the Arkansas State Medical Board. (The CCVSAC will represent all users and will perform periodic audits in accordance with established procedure [POLICY FOR AUDITS, POLICY NO. 95-4] to ensure the integrity of Arkansas State Medical Board processes and information available.)
- e. Contract format development for subscribers who use the service.
- f. Other policies as needed for operation of the credentials verification service.

**History:** *Adopted Feb. 3, 2000*

## **Regulation No. 13**

WHEREAS, the Arkansas State Medical Board is vested with discretion (pursuant to Arkansas Code Annotated §17-95-405) to issue a license to practice medicine to a physician who has been issued a license to practice medicine in another state, "whose requirements for licensure are equal to those established by the state of Arkansas" without requiring further examination; and in order to establish objective criteria of equivalency in licensure requirements, the Board hereby finds that all applicants for licensure who were graduated from an American or Canadian medical school prior to 1975 and who otherwise meet all other requirements for licensure in this state shall be determined to meet the requirements for licensure in this state upon presentation of satisfactory evidence that they have successfully completed the examination required by the licensing authority in the state in which they were originally licensed. All applicants for licensure who were graduated from an American or Canadian Medical School subsequent to 1975 shall be required to present evidence of satisfactory completion of one of the examinations listed in Regulation 14. Graduates of Canadian medical schools shall be deemed to have satisfied the equivalency requirements by providing proof of completion of the LMCC (Licentiate of the Medical Council of Canada) examination. Graduates of foreign medical schools must comply with the requirements of Regulation 3 and Regulation 14, regardless of the state in which they are licensed. All applicants must complete and submit such information as the Board requests on its application form for licensure by credentials. ■

**History:** *Adopted April 19, 1985; Amended Oct. 6, 2000*

# Report of AMS Benefits Inc.

By GERALD STOLZ, MD, CHAIRMAN OF THE BOARD

**A**MS Benefits Inc. is a fully owned subsidiary of the Arkansas Medical Society. Its purpose is to provide products and services to AMS members and their clinics. The AMS president automatically serves as chair of the AMS Benefits board. Other board members are Drs. Lloyd Langston, Joe Stallings, Dwight Williams, and AMS staff members Ken LaMastus, David Wroten and Lynn Zeno.

AMS Benefits has limited its product line to insurance products and is licensed by the Arkansas Insurance Department to sell life and health insurance products. This past year has seen a major shift in how AMS Benefits provides health insurance products. In July 2000, the Arkansas Insurance Department assumed control of Arkansas' second-largest insurer, American Investors Life Insurance Co.

At that time, approximately 90 clinics were covered by a group health

insurance plan sponsored by AMS Benefits and insured by American Investors.

AMS Benefits staff tried unsuccessfully for more than a year to find another carrier to underwrite the sponsored plan. Because of the current instability in the health insurance market, it was decided to abandon a single sponsored plan and instead individually place each of the 90 clinics with the health carrier of its choice.

Agent contracts were immediately sought with each of the major health insurance carriers, and, within four months, the task was completed.

In addition to the health insurance products, AMS Benefits also offers medical malpractice and a full line of personal and business insurance products. This is accomplished through a relationship with Hoffman Henry Insurance Corp. The distinguishing

feature of this agency is that it is the only agency with the ability to write malpractice coverage for the three major carriers.

Space does not permit a detailed explanation of the frustration and difficulties encountered by our clinic customers and our staff throughout the past year in responding to the American Investors crisis. Credit must be given to our staff members Alanna Scheffer and Karen Zimmerman and to Charles Horner of Hoffman Henry.

Through their tireless work, which included nearly three months of endless days and nights, the majority of clinics have chosen to continue purchasing their health coverage through AMS Benefits.

Let me take this opportunity to thank our staff and officers for their efforts and to encourage our members to call on AMS Benefits for their insurance needs. ■

## Collect Bad Debt

- Cheaper
- Faster
- In compliance with the Law



**We Collect  
Arkansas**

If you've always used a collection agency. . . WHY?

Cut out the collection agency by retaining the Maggio Law Firm.

Save time. Save money.  
Be in compliance with the law.

Have you always used a collection agency because "that's the way you've always done it?"

*Try a new way. . . tip the scales in your favor, call today.*

## MAGGIO LAW FIRM

*your collection law firm*

Offices in Conway and Searcy • 1-800-600-3201

[www.ebaddebt.com](http://www.ebaddebt.com)



# Report of the AMS Medical Student Section

BY DWIGHT J. JOHNSON, STUDENT SECTION CHAIR

The Medical Student Section has had a very successful and eventful year. The program at the University of Arkansas for Medical Sciences is extremely active in local and national medical and social issues. Membership is at an all-time high and remains at third or fourth on a per capita basis when compared to other schools in our six-state region.

We hope many members of the Arkansas Medical Society have noticed several new youthful and enthusiastic faces at such AMS-sponsored events as "A Day At The Capitol" or at the annual and interim AMS meetings. This trend demonstrates that our grassroots membership initiative will pay dividends long term in retained and continuing membership for our society. Now on to the specifics.

• **Legislative Awareness** — Through the efforts of Lynn Zeno and students Heather Diemer and Jacob Dickinson, the students at UAMS are ready to add their voices and numbers to any legislative issues identified by the Society. For instance, a phone tree has been created that can be activated by a single call. This should result in the presence of 50–100 students at the state Capitol to canvas and solicit support for various legislative concerns that might be raised during the legislative session.

Students are also kept apprised of the latest legislative alerts by dissemination of this information on the computer file servers at UAMS. All in all, students at UAMS are now more aware of legislative issues than ever before and are willing to support the Society's efforts in shaping appropriate legislative action for the doctors and their patients in Arkansas.

• **Community Projects** — The student section raised more than \$960 before Christmas for the under-

privileged children in the special education program at Bale Elementary School in Little Rock. We used this money to purchase educational Christmas gifts for the children and for educational supplies for several teachers at the school. Students Lisa Talbert and Justin McCoy did a great job soliciting donations and taking care of the logistical aspects of this project.

The national level of the Arkansas Medical Association Medical Student Section recognized our student section at the 2000 Annual National Meeting in Chicago with an award for supporting the national project for the year. The 1999-2000 national project was "Organ Donor Awareness." We received a \$100 award for having the greatest number of members who are organ donors.

This year's national project for the AMA Medical Student Section is the Children's Health Insurance Project (CHIP). The chair for the Arkansas version of this program is student Rebekah Craig-Nunez. She has done a great job in organizing the students at UAMS and in premedical programs across the state to rally behind sign up efforts to get larger participation in "ARKids First" (Arkansas' equivalent to CHIP).

On Dec. 16, she held the first medical student-sponsored rally and sign up program at McCain Mall in North Little Rock. This effort netted more than 120 positive sign ups for the program. This year, she continues to urge the student section to become more involved in other activities that focus on greater participation in the ARKids First program.

• **National Involvement** — At the interim 2000 AMA meeting in Orlando, Fla., we were honored as a model chapter for our work on a project that sought to increase membership in local, state and national

medical societies. We did this by approaching senior medical students and presenting the benefits of membership in an open forum.

I am currently serving in a liaison role with the National Board of Medical Examiners, and student section members Eric Shultz, Chuck Mashek and Heather Diemer have been selected to participate in the AMA's National Leadership Conference.

There have been numerous other students who have served or are currently serving on national committees for the student section.

• **Local Involvement** — On the local level, students are active in the changing face of the AMS. Examples include the many students who are filling roles on various standing and ad hoc committees in the AMS, as well as active committees within the medical student section, such as the Legislative Awareness Committee and the CHIP/ARKids First Committees.

There is never a lack of volunteers to support any of the initiatives that are brought to the medical student body at UAMS. And, beginning in 2002 with the expansion of student representation in the AMA House of Delegates, a student from Arkansas may well sit with the Arkansas delegation as a voting member.

So as you can see, the students at UAMS are actively involved in social and medical issues at both the local and national levels.

The Medical Student Section at UAMS would like to extend its great appreciation to the AMS and all the doctors in Arkansas for their continued support and recognition. Be assured that we seek to work with you in all of our efforts to improve the quality of health care for all Arkansans, and that we stand as a ready resource to be utilized by the Society toward that end. ■

# Arkansas Health Care Access Foundation Inc.

By MICHAEL C. YOUNG, MD, PRESIDENT  
AND PAT KELLER, LSW, CVM, PROGRAM DIRECTOR

**A**gain, it is my privilege to serve as president of the Arkansas Health Care Access Foundation Inc. (AHCAF) in the year 2001. I consider it an honor to represent, as well as participate in providing care through this program.

The progress of this organization has been extraordinary over the past 12 years! Its dedicated professionals continue their commitment to provide

*"He who  
has health  
has hope,  
and he who  
has hope  
has  
everything."  
— Arabian  
proverb*

for the medical needs of thousands of Arkansas' low-income non-insured. Care such as medical office visits, prescription assistance, hospitalization and dental pain relief is offered by more than 1,900 volunteer medical professionals.

More than 3,700 Arkansas enrollees were covered this year at an average cost to the program

of only \$27 per year.

An estimated \$250,000 in care was donated by the program's volunteer medical professionals. More than 2,400 referrals were for treatment, and more than 600 referrals were for other needed services. In addition to managing the program's services, our two-person staff handled more than 14,000 telephone inquiries this year.

Donated Dental Services (DDS), a service managed by AHCAF, consists of volunteer dentists, oral surgeons and dental laboratories that donate comprehensive dental treatment to disabled, elderly or medically compromised Arkansans. This past year, these dental volunteers provided \$60,000 in treatment. Even with a treatment waiting list of one to two years, DDS is a very popular service because it is the only formal resource of its kind in the state.

Crucial to the program's success is the support of professional associations representing the medical professionals

involved with the program. We are grateful to the Arkansas Medical Society for its ever-present, in-kind support and assistance. Continued thanks are extended to the Arkansas Hospital Association, the Arkansas Pharmacists' Association, the Home Care Association of Arkansas, the Arkansas Podiatric Medical Association and the Arkansas State Dental Association.

Our profound thanks also to the Arkansas Department of Human Services (DHS) for its financial support and the DHS county offices for their support in screening the majority of participants. AHCAF could not function without their invaluable assistance in linking individuals with our service.

The foundation continues its longstanding cooperation with the Arkansas Department of Health by providing treatment resources for patients participating in the Breast and Cervical Cancer Control Program and those needing followup for Pap smears.

Thanks goes to Pfizer, Johnson & Johnson and SmithKline Beecham pharmaceutical companies for donating their prescription medicines and again to Pfizer for covering the cost of reprinting our applications. Donations to the Tom Tapp Fund are always welcomed and are used to purchase necessary medicines when not donated or affordable for certain patients.

Continued collaboration with the Community Health Centers of Arkansas, UAMS and AHECs, as well as many faith-based volunteer health clinics, helps us to reach and assist more Arkansans.

We are especially thankful to our volunteer board and the AHCAF volunteer medical professionals for their untiring commitment and their gifts of time and energy.

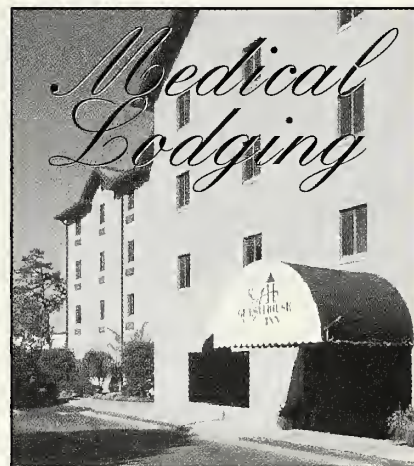
If you are not involved with the Arkansas Health Care Access Foundation, please consider volunteering by calling Pat Keller or Connie Coe at (800) 950-8233. ■

## ARCHITECTURE

FOR YOUR MEDICAL NEEDS

1 800 764 ASTI

**William Henry Asti, AIA**  
architects, economists, development consultants



*Close proximity  
to all Little Rock hospitals*

Serving Little Rock Visitors

- Medical stays
- Business travel
- Leisure travel

*"Guesthouse Inn is your perfect home  
away from home while in Little Rock"*

**GUESTHOUSE**  
Inns • Hotels • Suites

301 S. UNIVERSITY AVE. LITTLE ROCK  
501-664-6800



# Physicians' Health Committee Arkansas Medical Foundation

By JOE L. MARTINDALE, MD, MEDICAL DIRECTOR

**T**he Physicians' Health Committee was formed to intervene, assist and advocate for physicians with substance abuse problems. Funding for the foundation is provided through an increase in licensure fees of all Arkansas physicians. The Arkansas Medical Society provides administrative support and other contributions, such as those from the State Volunteer Mutual Insurance Co., and a small fee is collected from individuals in the program. The Arkansas Medical Foundation is a 501(c)(3) organization. All inquiries and assistance are considered confidential.

Members of the board of directors are Larry Lawson, MD, Paragould, president; Joanna Seibert, MD, Little Rock, vice president; Karen Ballard, Little Rock, secretary/treasurer; Jerry Stringfellow, MD, Texarkana; and John Lynch, DO, Jonesboro. Ex-officio members are Ray Jouett, MD, Little Rock, chairman of the Arkansas State Medical Board; and Ken LaMastus, Little Rock, executive vice president of the Arkansas Medical Society.

#### Activities for 2000 included:

- Participants in our program include physicians, licensed respiratory-care therapists, dentists, dental hygienists and optometrists.
- Currently, 73 participants are being monitored, as well as 10 physicians from other states who serve as "locum tenens" in Arkansas.
- Seven physicians and three dentists have had relapses in the past four years. Two of these physicians are no longer practicing medicine, and the other five have successfully completed their treatment for relapse and are being monitored by the committee. Two dentists have successfully completed their treatment for relapse and are currently being monitored by the committee. One dentist surrendered his license.
- We continue to work with HMOs, PPOs, hospital credentialing committees, malpractice carriers, probationary officers, state medical boards, state monitoring programs, respective Arkansas licensing entities and the DEA to help physicians to continue practicing medicine and dentistry in the state of Arkansas.
- We are working with Arkansas hospitals to assist them with complying with the new JCAH Medical Staff Regulation MS.2.6, which states the medical staff will implement a process to identify and manage matters of individual physician health that is separate from the medical staff disciplinary fashion.
- We continue to keep participants informed of continuing medical education courses related to substance abuse, prescription writing, sexual issues, ethics, stress management and other topics of interest. ■

**G o t  
s o m e  
i s s u e s**

**you'd like  
to see  
addressed  
in  
The Journal?  
call Natalie  
Gardner at  
(501) 372-1443  
or e-mail  
ngardner@abpg.com.**



#### Healthcare Professional Liability Business/Workers' Compensation/ Life & Retirement Planning

Managing the business side of healthcare is time consuming, but FARMERS helps get you back where you belong—delivering quality medical care.

For almost 50 years, Farmers has been a well respected carrier. We provide the highest quality products and services to all types of physician groups. We know our business.

Our professional team has an established background in medical services and management. We are committed to working in our client's best interests, offering premier claims and risk management services—with coverage especially for the physicians.

*A.M. Best rating of A+ (Superior)*



Mark Pery  
76 Municipal Drive  
Jacksonville, AR 72076  
(501)982-4561 • 1-800-467-2436  
mperry@alltel.net

Stop by the Farmers exhibit at the  
2001 Arkansas Medical  
Society's Expo  
May 4th and 5th and enter our raffle.  
Pick up a complimentary gift and  
ask us about coverage.



Joanna Owens  
712 A Bradley Dr  
Mtn. Home, AR 72653  
(870) 424-2120 • 1-888-424-2120  
baxterinsurance@yahoo.com

# Arkansas Department of Health 2000 Report

The Arkansas Department of Health continues its role in assuring conditions that provide a healthier quality of life for all Arkansans. In 2000, the department performed these new activities to improve Arkansas' health status:

- Hosted the first Arkansas Cancer Summit to develop a statewide comprehensive cancer control plan.
- Expanded Hometown Health Improvement. Sites include Baxter, Boone, Fulton, Madison, Washington, Crittenden, Scott, Polk, Montgomery, Garland, Phillips, southeast Pulaski, Drew, Nevada, Pike, and Union counties. Each community is working to identify its unique health needs. Several sites implemented programs to address these needs; others are in the data collection/assessment phase.
- Published "A Look at Diabetes in Arkansas," defining Arkansas' diabetes burden.
- Established a statewide Diabetes Advisory Council to develop a Diabetes Strategic Plan.
- Partnered with other organizations to establish a "Wellness Coalition" to address preventive health and chronic disease needs.
- Partnered with the Centers for Disease Control and Prevention (CDC) to investigate peripartum cardiomy-

opathy in southern Arkansas and improve evaluation of the state's perinatal mortality.

- Conducted the first-ever statewide oral health needs assessment.
- Reinstated a program to assist Arkansas' dentists and physicians in prescribing fluoride supplements for children.
- Initiated the Arkansas Birthing Project to encourage healthier birth outcomes.
- Began the Promotoras Health Education/Risk Reduction Program to provide health education in central Arkansas' Hispanic/Latino communities.
- Received a CDC grant to expand the Early Hearing Detection and Intervention System.
- Promulgated regulations for Universal Newborn Hearing Screening in hospitals.
- Received a CDC grant to study falls and fires experienced by the elderly in Mountain Home, Mena and southeast Pulaski County.
- Awarded Abstinence Education funds to 14 projects (six education-based, five community-based and three faith-based).
- Began developing a centralized core injury information base for injury data and injury prevention programs statewide.
- Made Pneumococcal conjugate vaccine (Prevnar) available

to private physicians participating in the Vaccine for Children program.

- Implemented Prenatal and Early Childhood Nurse Home Visiting in 14 counties to provide health supervision, parenting education and support to pregnant teens.
- Completed the Obesity Task Force study of the impact of obesity in adults and children; made prevention and treatment recommendations.
- Supported initiatives to address tobacco's impact on the state's minority population by coordinating tobacco-specific activities targeting minority communities; funding community-based planning; partnering with the University of Arkansas at Pine Bluff to recommend strategies to prevent

## Selected Statistical Indicators

### Maternal and Child Health

Child Health Patients .....	26,561
EPSDT Screening .....	16,840
Family Planning Patients .....	56,382
Maternity Patients .....	14,595
WIC Clients .....	145,558

### Communicable Disease Control

AIDS Testing/Counseling .....	82,067
TB Skin Tests .....	90,510

### Immunizations

HIB .....	103,259
DTAP/DTP/DT .....	124,567
TD (Adult) .....	43,205
MMR/MR/Mea .....	138,259
OPV/EIPV .....	108,952
Hep B .....	225,206
Varicella .....	48,532
Pneumococcal Conjugate .....	5,285

### Breast and Cervical Cancer Control

Screening Mammograms .....	3,182
----------------------------	-------

Screening Pap Smears .....	1,906
----------------------------	-------

### In-Home Services

Patient Admissions .....	27,553
Home Health Visits .....	303,658
Home Care Visits .....	104,162
MIP Visits .....	12,515
Hospice Days .....	37,199
Personal Care Hours .....	1,519,920
ElderChoice Hours .....	465,733
Case Management Units .....	185,627

### Substance Abuse Treatment

Adults Served .....	13,105
Adolescents Served .....	459
Regional Alcohol and Drug Detoxification (RADD) Patients ....	2,423
Alcohol Safety Education Program Offenders Educated .....	14,203

### Laboratory Samples Analyzed

.....	439,569
-------	---------



## Blues, Barbecue, Botanic Gardens.



Beale Street, Sunset Symphony, Orpheum Theatre and charming southern hospitality make Memphis, Tennessee a wonderful place to call home. Enjoy the laid back lifestyle of working in West Memphis, Arkansas but all the amenities of the largest city in Tennessee.

### Seeking a Leader and a Team Player

**Crittenden Memorial – Emergency Department**  
West Memphis, Arkansas

#### ♦ 110 Per Hour for Full-Time and Part-Time

- ♦ 19,000 Patient Visits Annually in 10 bed Emergency Department
- ♦ Located 10 Minutes from Downtown Memphis
- ♦ Health, Life, Dental, & Retirement Plan Options plus \$2,000 CME
- ♦ Relocation Assistance and Malpractice Insurance with Tail
- ♦ Criteria: BE/BC Primary Care or Emergency Medicine
- ♦ One Staff and One Medical Director Position Available March 1<sup>st</sup>
- ♦ Excellent Monthly Stipend for Medical Director

*Don't Miss Out – Call Now!!*

Jennifer Strouse @ 800-362-2731 ext. 2014

Email: [jennifer\\_strouse@emcare.com](mailto:jennifer_strouse@emcare.com) or Fax your CV to 214-712-2444

An Equal Opportunity Employer

[www.EmCare.com](http://www.EmCare.com)



**continuing  
medical  
education**



Office of Continuing Medical Education...

**Committed to Life-Long Learning**

### 2001 Programs

#### May 5 W.W. Stead Chest Symposium

Location: The Austin Hotel, Hot Springs, AR

#### May 11 The Diamond Conference

Location: The Riverfront Hilton Inn, North Little Rock, AR

#### May 19 The Diabetes Update 2001

Location: The Holiday Inn Select, Little Rock, AR

#### June 1-3 23rd Annual Family Practice Intensive Review

Location: UAMS Education II Building, Little Rock, AR

For additional information,

call the Office of Continuing Medical Education at (501) 661-7962  
or check out our website, [www.uams.edu/cmefd/cme2.htm](http://www.uams.edu/cmefd/cme2.htm)

youth initiation; promote cessation, eliminate exposure and eliminate disparities among minority populations in relation to tobacco use; and sponsoring the first Minority Tobacco Summit.

- Partnered with the Arkansas Minority Health Commission and local churches to sponsor a Central Arkansas Health Fair.
- Collaborated with Region VI Department of Health and Human Services to sponsor a Regional Disparity Health Conference to develop the best strategies for eliminating health disparities.
- Received a grant to assess/plan for meeting the health needs of Marshall Island immigrants in northwest Arkansas.
- Compiled and disseminated a Minority Health data book for 1993-97.
- Trained six laboratory technicians from Russia, Hong Kong and Canada in tuberculosis testing; participated in training a World Health Organization laboratory director assigned to Uganda.
- Added the rapid EIA (SUDS) test for HIV-1 to support occupational exposure protocols. Fifteen-minute results allow post exposure prophylaxis within two hours.
- Received a CDC Bioterrorism Grant to increase capacity to test for biological agents most likely to be used by bioterrorists.
- Partnered with the UAMS Medical Technology School to rotate students through the parasitology and enteric laboratories.
- Licensed a three million Curie irradiator to sterilize medical products; licensed a mobile Positron Emission Tomography (PET) unit to provide mobile scanning services.
- Implemented the Radiologic Technology Licensure Program; licensed 4,089 individuals administering ionizing radiation to humans.
- Monitored selected water sources for radon.
- Approved funds through the State Health Building /Local Grant Trust Fund to construct or improve health units in Logan, Pike, Lonoke, Sebastian, Garland, Polk, Lincoln, Desha, and Calhoun counties. ■

# Pulaski County Medical Society 2000 Annual Report

BY CAROLYN BRUMMETT, EXECUTIVE DIRECTOR

**S**amuel B. Welch, MD, and board of directors Drs. Anthony D. Johnson, president-elect; David E. Bourne, vice president; Denise R. Greenwood, secretary; Steven W. Strode, treasurer; and C. Reid Henry, immediate past president, led the Pulaski County Medical Society through a year of unprecedented growth. Membership grew by approximately 8%, exceeding 1,000 active, emeritus and student members.

To better serve members and see if the organization was meeting objectives, the Pulaski County Medical Society undertook a strategic planning process. A mail-back survey of all physicians in the county had a 30% response rate from members and 15% from nonmembers. Both groups gave "educating the public" and "impacting health policy" the highest ranking.

Responding to survey results, and in collaboration with the Arkansas Medical Society, the Pulaski County Medical Society launched an educational campaign in support of a

proposed ban on smoking in restaurants. The decision to support this issue publicly was based on survey results and the planning process. *Arkansas Business* published a guest editorial from the Pulaski County Medical Society in support of the ban.

Awareness of the Pulaski County Medical Society was enhanced through regular publication of *PCMS News*. Issues, members, students and special events were featured in *Arkansas Business*, *Arkansas Democrat-Gazette*, *AMS Journal* and *PCMS News*. A Carrier Relations Committee was formed to improve communication with insurance carriers.

Two new social events were hosted by the Society in 2000 — a spring social at the home of Dr. Denise Greenwood and a fall social at Milford Track Restaurant. The annual Doctor-Lawyer Dinner was held at Embassy Suites, and the Annual Meeting and Christmas Party was at the Capital Hotel.

The Pulaski County Medical Society Web site, [www.pulaskicms.org](http://www.pulaskicms.org), was activated in 2000. The site offers links to AMS, AMA and ABMS. The PCMS Membership Directory is available through a secure "Members-Only" section, and a printable membership application is available as well.

More than 60 members, representing eight clinics, have taken advantage of a new Medical Exchange service for alpha numeric paging. The exchange has been automated with capability for Internet paging service.

A demographics study of Pulaski County Medical Society members indicated that 82% are board-certified, 84% are male and 16% are female. Practice locations include Little Rock, 81.5%; North Little Rock, 10%; Jacksonville, 3%; Sherwood, 3%; and other, 2.5%. Fifty-six percent are University of Arkansas for Medical Sciences graduates. Five percent are graduates of foreign medical schools, and members represent 19 foreign countries. ■

---

## CME Accreditation Committee Report

BY STEVEN STRODE, MD, CHAIRMAN

**T**he Continuing Medical Education Accreditation Committee is charged with the responsibility to accredit intrastate sponsors of continuing medical education (CME). The committee accredits organizations such as hospitals, not individual CME activities. Among other benefits, accreditation bestows upon an organization the privilege of designating CME activities for the AMA Category 1 credit. Only accredited CME sponsors may designate activities for AMA credit.

During 2000, the committee met on three occasions. The committee reviewed five of our nine sponsors during 2000 and took the following accreditation actions:

- Conway Regional Medical Center, Conway—two years full accreditation
- National Park Medical Center, Hot Springs—two years full accreditation
- St. Joseph Regional Health Center, Hot Springs—two years full accreditation
- St. Vincent Infirmary Medical Center, Little Rock — two years full accreditation

- VA Medical Center, Fayetteville — two years full accreditation

Other sponsors are as follows: Baptist Health Medical Center, Little Rock; Baxter Regional Medical Center, Mountain Home; North Arkansas Regional Medical Center, Harrison; and Washington Regional Medical Center, Fayetteville.

CME accreditation is accomplished under the auspices of the Accreditation Council for Continuing Medical Education (ACCME). The national organization, consisting of seven parent



# CELEBRATING 10 YEARS OF IMPROVING PHYSICIANS' BOTTOM-LINE



*"Keeping the practice of  
medicine independent"*

## PHYSICIANS MANAGEMENT SERVICES, INC.

- Coding
- Billing
- Receivable Management & Management Consulting
- Transcription

Scott McCall & Linda Cochran • 2909 Military Road, Benton, AR 72015  
1-800-353-6165 • e-mail: pms112291@aol.com • www.physiciansmgmt.com



## PhyAmerica Physician Services, Inc.

### WALNUT RIDGE, ARKANSAS EMERGENCY MEDICINE OPPORTUNITIES

#### Director Position Just Added!

- Seeking BC/BP Physicians for Directorship, and
- BC/BP Physicians or Third Year Residents w/EM or PC Specialty for Staff Positions.
- ACLS Required; Annual Volume: 7,500.
- Primary & Supplemental Coverage needed.
- 15 Minutes NW of Jonesboro, AR and 1 hour NW of Memphis, TN.
- Procured Liability Insurance, IC status, no restrictive covenants.

For more information, contact Physician Recruiter,  
**Amy Inter at 800-476-5986**  
or fax your CV to 919-382-3274 or e-mail ainter@phyamerica.com  
**PhyAmerica Physician Services, Inc.**  
**2828 Croasdaile Drive, Durham, NC 27705**

organizations including the American Medical Association and the American Hospital Association, has established a nationwide system of accreditation for sponsors of CME. The ACCME directly accredits sponsors whose scope is national or regional. For intrastate sponsors, the ACCME has established a "recognition" system whereby they recognize certain organizations, usually state medical societies, to conduct the accreditation functions within their state.

In 1999, a recognition survey of the AMS was conducted by the ACCME's Committee for Review and Recognition. Satisfactory completion of the survey is a requirement for the AMS to maintain its "recognized" status.

The Arkansas Medical Society was approved as an accreditor for intrastate providers for another four-year term in March 2000. It is also my pleasure to have been appointed to the Committee for Review and Recognition (CRR) for one three-year term.

The Arkansas Medical Society hosted the Southeast CME Symposium with the state medical associations of Alabama, Mississippi and Louisiana. The 2000 symposium was held in Memphis, Tenn., and was attended by more than 75 CME coordinators and physicians.

My report would not be complete without calling your attention to the amount of time and energy expended by the committee members and the AMS staff. For each of the accreditation decisions mentioned above, many hours of preparation are involved in reviewing applications, in conducting the mandatory on-site survey of the sponsor and in developing the reports and summaries of our findings.

In addition, David Wroten and Kay Waldo handled many inquiries from sponsors and prospective sponsors, often necessitating on-site consults at locations around the state. Many thanks for the time and effort of our committee members — Drs. Philip Duncan, Fayetteville; W. Turner Harris, Little Rock; Carlton Chambers, Little Rock; Bob Cogburn, Mountain Home; Joanna Thomas, Fayetteville; and Anupama Athota, Little Rock, medical student. ■

# PEOPLE+EVENTS

## HONORED

### El Dorado Doctor Honored with Award

Dr. Bill Scurlock of El Dorado was recently awarded the Ethel K. Millar Award for Religion and Social Awareness during the 16th annual Steel-Hendrix awards presentation at Hendrix College in Conway.

Dr. Scurlock is a retired surgeon who specialized in general, trauma and vascular surgery. He is a 1956 graduate of Hendrix College and received his medical degree from the University of Arkansas for Medical Sciences.

As a volunteer, Dr. Scurlock takes surgical mission trips to Third World countries. He has been interviewed on local and national

news programs concerning the surgeries he's done on these trips.

Besides his mission trips, Dr. Scurlock is a certified lay speaker for the United Methodist Church, attending physician at the Migrant Workers Clinic in Hermitage, and is on the boards of directors for the University of Arkansas Medical Foundation, the United Methodist Foundation of Arkansas and the Methodist Children's Home. He is also on the board of governors of the Southern Arkansas University Foundation.

### Physicians Receive Awards from AMA

Each month, the American Medical Association presents the Physicians'

Recognition Award to those who have completed acceptable programs of continuing education.

AMA recipients for January are **Drs. H. M. Attwood** of Pine Bluff, **Jimmy D. Bonner** of Paragould, **Jay O. Brainard** of Little Rock, **James D. Busby** of Alma, **Peter J. Carroll** of El Dorado, **Jimmy C. Citty** and **David M. Evans** of Searcy, **Richard L. Hayes** of Jacksonville, **Francis P. Maloney** of Little Rock, **Robert H. Nunnally** of Camden and **Clarence E. Ransom** of Searcy.

in Greenwood, was a member of the Sebastian County Medical Society, the Arkansas Medical Society and the American Medical Association. He was a Greenwood School Board member for 20 years, a member of Harris-Hannah VFW Post 6572, a member of Greenwood First Baptist Church, a 32nd-degree Mason, Greenwood Lodge 131 F&AM, and a veteran of the Army Air Corps and World War II.

He is survived by his wife, Waylen; a son, John Bailey and wife, Natalia, of Mobile, Ala.; a daughter, Joan Van Vactor of Augusta, Ga.; a sister, LaRue Joyner and husband, John, of Little Rock; and a grandson, Charles N. Bailey. ■

## OBITUARIES

### Charles W. Bailey, MD

Dr. Charles W. Bailey, 80, of Greenwood, died Feb. 6.

Dr. Bailey practiced family medicine for 30 years

## New Members

### Kimball B. Pate, DO

Specialty: Resident-FP  
4010 Mulberry St.  
Pine Bluff, AR 71603  
(870) 541-6010

### Kathleen Paulson, MD

Specialty: OBG  
3276 N. North Hills Blvd.  
Fayetteville, AR 72703  
(501) 442-7030

### Jason S. Paxton, MD

Specialty: Resident-FP  
601 W. Maple Ave., #102  
Springdale, AR 72764  
(501) 750-6585

### Hilary A. Peterson, MD

Specialty: Resident-EM  
11702 Pleasant Ridge Ct., #218  
Little Rock, AR 72223

### Corwin D. Petty, MD

Specialty: Resident-FP  
601 W. Maple Ave., #102  
Springdale, AR 72764  
(501) 780-6585

### Rachel M. Rogers, MD

Specialty: PD  
500 S. University Ave., #302  
Little Rock, AR 72205  
(501) 664-4044

### Tracy L. Rowe, MD

Specialty: PD  
2425 Prince St.  
Conway, AR 72032  
(501) 329-1800

### Ron D. Schechter, MD

Specialty: ORS  
1000 W. Kingshighway, #10  
Paragould, AR 72450  
(870) 236-2400

### Shailesh R. Shah, MD

Specialty: Resident-AN  
4301 W. Markham St.  
Little Rock, AR 72205  
(501) 686-5000

### Walter Short, MD

Specialty: FP  
1909 W. Elm St.  
El Dorado, AR 71730

### David Alfred Sitzes, MD

Specialty: FP  
P.O. Box 438  
Calico Rock, AR 72519  
(870) 297-8081

### Lynette Smith, MD

Specialty: PD  
101 Skyline Drive  
Russellville, AR 72801  
(501) 968-2345

### Todd P. Smith, MD

Specialty: Resident-VS  
2200 Riverfront Drive,  
#7308  
Little Rock, AR 72202  
(870) 257-6859

### Edgar A. Sotomayor, MD

Specialty: Resident-PTH  
4301 W. Markham St., #502  
Little Rock, AR 72205  
(501) 686-7015

### Sarah L. Sullivan, MD

Specialty: FP  
State Highway 14 East  
Mountain View, AR 72560  
(870) 269-4144

### Sheila B. Triplett, DO

Specialty: Resident-FP  
4010 Mulberry St.  
Pine Bluff, AR 71603  
(870) 541-6010





**Let's Go!**  
**833-5600**

**AIR CHARTER EXPRESS**

**24 HOUR AIR CHARTER & AIR FREIGHT FAA CERTIFIED**

## ***TOTAL DOCUMENT SOLUTIONS, INC.***

**Provide your front-office  
personnel with 360-degree  
view of all patient records:  
medical Records, EOB's,  
Standard Insurance, Billing  
Information with**

**DOC *X* net**



Minolta  
Information  
Systems, Inc.

***FREE ESTIMATES  
Onsite and Offsite  
Conversion Provided***

***Toll Free 1-866-467-8244***

**Doc-Xnet is a browser-based document management  
and workflow system that ties enterprise documents  
together into easily accessible folders that can be  
delivered ANYWHERE in the world, ANYTIME.**

### **Richard D. Tutt, MD**

Specialty: FP  
775 E. Douglas  
Prairie Grove, AR 72753  
(501) 267-5600

### **Raymond P. Valdes, MD**

Specialty: IM  
228 Tyler St., #200  
West Memphis, AR 72301  
(870) 735-1973

### **Sara Elsie VanScoy, MD**

Specialty: P  
2712 E. Johnson  
Jonesboro, AR 72401  
(501) 268-4115

### **William R. VanScoy, MD**

Specialty: P  
2712 E. Johnson  
Jonesboro, AR 72401  
(501) 268-4115

### **Imran Waheed, MD**

Specialty: Resident-FP  
4010 Mulberry St.  
Pine Bluff, AR 71603  
(870) 541-6010

### **John Waller, MD**

Specialty: ORS  
1708 W. Main St.  
Heber Springs, AR 72543  
(501) 362-6631

### **Medical Students**

Alison A. Acott  
Safdar Ali Akbar  
John P. Akins  
Claudia M. Ancalmo  
David E. Arthur  
Darrin D. Ashbrooks  
Amy E. Bailey  
Lisa R. Barker  
Jason D. Beck  
David L. Bibbs  
Samuel E. Bledsoe  
Robin I. Bohra  
Billynda L. Booth  
Leah E. Braswell  
Donna Brown  
Scott P. Brown  
Jenny Campbell  
Sherri R. Carter  
Sean P. Casey  
James E. Cassat  
John C. Cawyer  
Cari L. Cordell  
Krista J. Cordon  
Brian W. Counts  
Stacy L. Crider  
Owen K. Criner  
Andrew D. Daniel  
Kimberly A. Dannull  
Jeremy C. Davis





*Tanyard Springs' guests can enjoy fishing in the Tanyard Pond, which is stocked with bass, catfish, crappie and bream. On the right is the Woodsman cabin, nicknamed "Little House on the Prairie" for its rustic and cozy atmosphere.*

## Tanyard Springs

Resting peacefully atop beautiful Petit Jean Mountain is a resort that's unmatched in Arkansas.

Created by a psychologist, not a developer, Tanyard Springs offers an atmosphere of rest, relaxation, reflection and recreation. Visitors can choose to do nothing but unwind in the comfortable cottages, or they can take advantage of Petit Jean Mountain's natural beauty, breathtaking scenery and panoramic views.

Tanyard Springs is unique in that each of its cabins and furniture were all handcrafted using natural materials from the area. And each cabin's decor is different from one another — each creatively designed to offer a distinct feeling and experience. Although each has its own personality, all of them are authentic replicas of the past.

For instance, the Springhouse cabin was restored from the original historic building of 1939 where the "purest spring water in the world" was once bottled. In the Mountaineer cabin, an entire 35-foot cedar tree trunk forms the staircase to the quaint loft. The Gambler cabin has a five-card-stud poker game inlaid in the dining table, and the Stagecoach cabin features an authentic 1800s stagecoach transformed into a bed, a favorite with the kids. Another favorite is the Shepherd cabin, whose downstairs bed is a wagon complete with wheels. The other cabins are equally charming, each taking guests a step back in time.

In addition, all cabins are equipped with a woodburning fireplace, and pure, natural spring water is piped into each cabin for both drinking and bathing.

Each cabin comes with porch furniture, an outdoor grill, picnic table and hammock.

Guests who enjoy fishing should feel right at home at Tanyard Springs. The Tanyard Pond is stocked with bass, catfish, crappie and bream. Visitors are welcome to keep the fish they catch and no license is required. The resort also has miniature golf, volleyball, horseshoes and a private hiking trail. Tanyard Springs guests also have access to a private overlook called Sunrise Point.

And next door to the resort headquarters is Petit Jean State Park, so visitors can enjoy the park's swimming pool and tennis court or just take in the beauty at the park's six popular overlooks and hiking trails.

Tanyard Springs is not only known locally but nationally as well. It was selected by a group of travel experts, along with the readership of *Family Circle* magazine, as one of the top five resorts in North America.

Rates for the cabins vary per night, ranging from \$125, \$150 and \$175. Weekly rates are available. A two-night minimum stay is required on the weekends. ■

Tanyard Springs, 144 Tanyard Springs Road, Morrilton, Ark. 72110. For information, call (501) 727-5200.



## ADVERTISERS INDEX

Air Charter Express .....	392
AMS Benefits Inc. ....	374
Arkansas Business.Com .....	Back cover
Arkansas Financial Group Inc., The .....	364
Arkansas Foundation for Medical Care .....	Inside front cover
Arkansas Managed Care Organization .....	376
Asti, William Henry, AIA .....	385
Central Flying Service .....	373
Easter Seals .....	378
EmCare .....	388
Farmers Insurance Group .....	386
Fiser Hummer .....	364
GuestHouse Inn .....	385
Hoffman-Henry Insurance Corp. ....	370
Lee Pharmacy .....	378
Little Rock Medical Associates .....	394
Maggio Law Firm .....	383
Medical Practice Consultants Inc. ....	372
MedPlus Quotes .....	373
Micheal Munson, A.G. Edwards & Sons Inc. ...	Inside back cover
Mr. Wicks .....	371
PhyAmerica Physician Services Inc. ....	390
Physicians Management Services Inc. ....	390
Pro Travel .....	370
Southwest Hospital .....	371
State Volunteer Mutual Insurance Co. ....	363
Total Document Solutions Inc. ....	392
University of Arkansas for Medical Sciences .....	372
University of Arkansas for Medical Sciences Continuing Education .....	388

Special Publications  
Publisher  
*Brigette Williams*

Special Publications  
Editor-in-Chief  
*Natalie Gardner*

Managing Editor  
*Shelby Brewer*

Editorial Assistant  
*Susan Van Dusen*

Sales Manager  
*Stephanie Hopkins*

Account Executive  
*Liz Earlywine*

Director of Design  
and Circulation  
*Virgeen Healey*

Production and  
Circulation Coordinator  
*Jeremy Henderson*

Editorial Art Director  
*Irene Forbes*

Advertising Art Director  
*Nikki Cruse*

Photographer  
*Mark Wilson*

Advertising Coordinator  
*Kristen Heldenbrand*

Marketing Assistant  
*Mitzi Tiffie*

Database Administrator  
*Andrea Martin*

Advertising Assistant  
*Greg Duszota*

 **ARKANSAS BUSINESS  
PUBLISHING GROUP**

Chairman & Chief Executive Officer  
*Olivia Farrell*

President and Publisher  
*Jeff Hankins*

Executive Vice President  
*Sheila Palmer*

© 2001 Arkansas Business Publishing Group  
[www.abpg.com](http://www.abpg.com)

## Get Published!

Give something back  
to your profession...  
write an article for

**THE  
Journal**  
OF THE ARKANSAS MEDICAL SOCIETY

*The Journal* needs your thoughts and ideas. So why not consider putting your expertise and experience on paper?

The Arkansas Medical Society is a statewide organization that represents all physicians, regardless of location or type of practice.

The result is a statewide network united for the common good of the medical profession. The staff of the Arkansas Medical Society provides members with the best information and services available.

For information about submitting an article to *The Journal of the Arkansas Medical Society*, call Judy Hicks at 501-224-8967 or 1-800-542-1058.

Doctors Complex with over 275,000 square feet of Class A Medical Office space is conveniently located in the heart of Little Rock's Medical Corridor and within a three mile radius of St. Vincent Infirmary, UAMS, Baptist Medical Center, Little Rock's VA Hospital, Arkansas Childrens' Hospital and adjacent to St. Vincent Doctors Hospital.

**LRMA**

**DOCTORS BUILDING - DOCTORS PLAZA**

**SUITES**

**AVAILABLE**

**FROM**

**496 SQUARE FEET**

**TO**

**5224 SQUARE FEET**

### LEASING INFORMATION:

Betty Garcia Little Rock Medical Associates

Phone: 501-664-1812

Fax: 501-664-9212

E-mail: [egarcia@lrma.com](mailto:egarcia@lrma.com)

# Don't Stop Planning Even In The Face of Estate Tax Reform

Contributed by:

Micheal D. Munson

Senior Vice President-- Investments

A.G. Edwards

1501 N. University, Suite 100

(501) 664-9135

**R**ecent stories in the news have discussed possible changes of the estate tax laws. Nothing will probably happen this year, but one day the estate tax may be reduced or even eliminated. That doesn't mean you should throw your estate plan out the window or delay putting such a plan in place.

In a flurry of activity before the Republican National Convention, the Senate voted on and passed legislation that would have repealed the estate tax over a ten-year period. Your heirs would have incurred substantial estate taxes if you had died before 2010 due to this legislation. President Clinton has vetoed this particular bill, but there are 50 bills currently under consideration in the legislature this year concerning changes to the estate tax laws.

This bill also includes a provision that would eliminate the step-up in cost basis at death for many estates. What does this mean to you? Presently, only about two percent of estates have an estate tax liability, but all estates receive a step-up in tax basis on capital assets to the date of death value. For example, under current law you inherit a house purchased by your deceased father for \$100,000. The house is then worth \$500,000 at your father's death. You could sell the house immediately and pay no capital gains tax because your cost basis would have "stepped up" to \$500,000. But, if the "step-up" is eliminated on the house, you could owe \$80,000 in taxes if you



sold the house. To come up with that figure you would subtract the original amount (\$100,000) from the present value of the house (\$500,000). Then multiply that number by 20% capital gains tax.

The objective of this example is to show that for every tax reduction, we must expect an increase somewhere else.

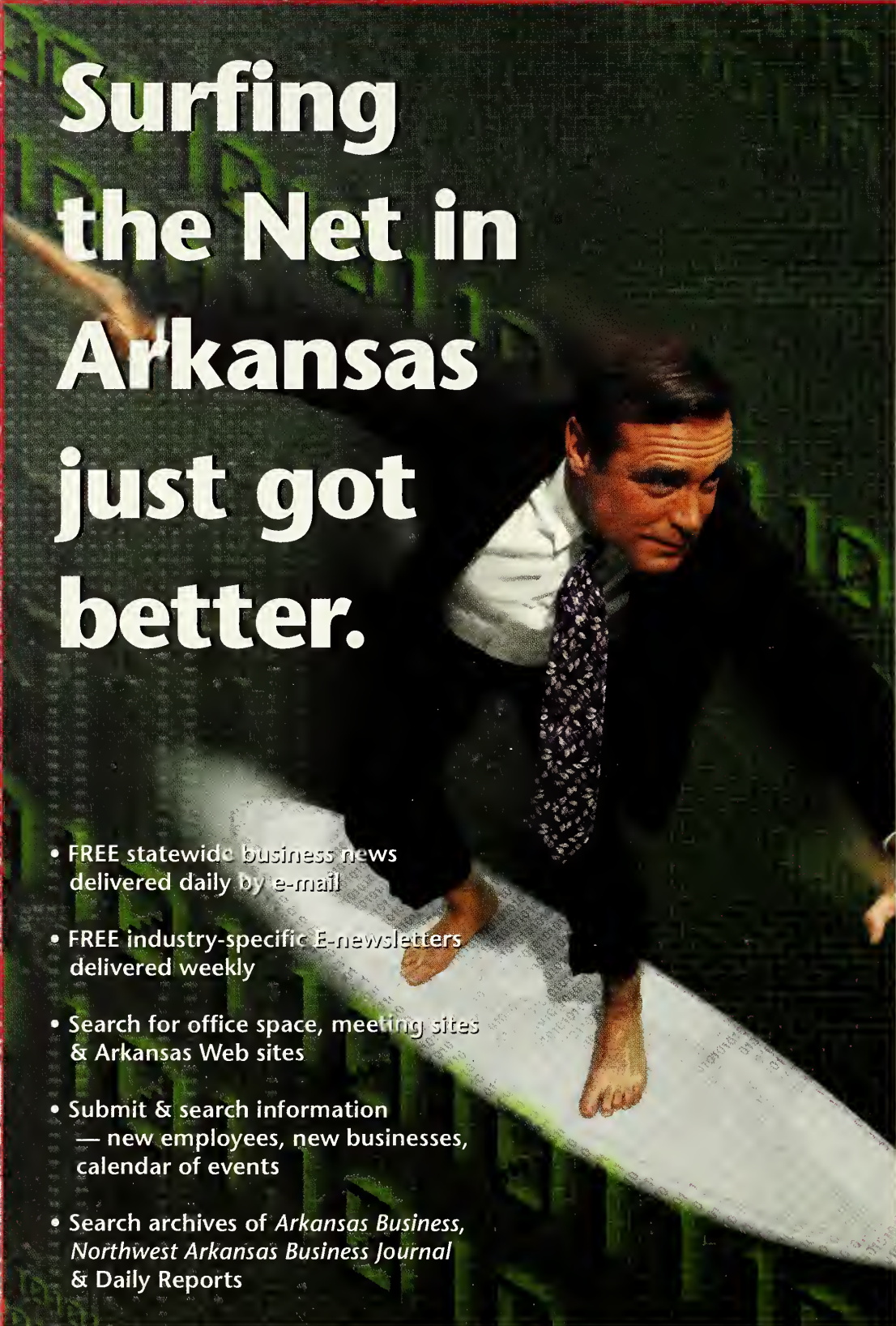
Anticipating tax legislation has always been difficult if not impossible. Income tax rates were reduced to 28% in 1987. But in only three short years, the maximum was raised to 33% and then to 39.6% three years after that. But the fact that tax rates and rules can change dramatically and quickly does not prevent most of us from planning to reduce taxes.

Likewise, a good solid estate plan will protect you now and can provide the flexibility to deal with tax law change in the future. And remember that estate planning is much broader than simply reducing or avoiding estate tax. You must also plan to distribute assets, to manage them for beneficiaries and to protect yourself and your family in the event of your incapacity among the other estate planning objectives. Specific questions on taxes as they relate to your individual situation should be directed to your tax advisor. Your estate plan may make a world of difference to you and your heirs.

**This article was provided by A.G. Edwards & Sons Inc., Member SIPC.**



# Surfing the Net in Arkansas just got better.



- FREE statewide business news delivered daily by e-mail
- FREE industry-specific E-newsletters delivered weekly
- Search for office space, meeting sites & Arkansas Web sites
- Submit & search information — new employees, new businesses, calendar of events
- Search archives of *Arkansas Business*, *Northwest Arkansas Business Journal* & Daily Reports

The State's #1  
Source for  
**Arkansas**  
Business Information



For sponsorship opportunities, contact  
at 372-1443 or [jhankins@abp](mailto:jhankins@abp)



# THE JOURNAL

OF THE ARKANSAS MEDICAL SOCIETY

Vol. 97 No. 12

June 2001

## Healing Honduras



HS/HSL  
UNIVERSITY OF MARYLAND AT  
BALTIMORE

MAY 16 2001

STACKS  
REC'D

NOT IN CIRC.



\*\*\*\*\*MIXED ADC 640

Health Sciences Library  
University of Maryland  
Collection Development Dept.  
601 West Lombard St.  
Baltimore MD 21201

S55 P7





In your job every decision is

# CRUCIAL

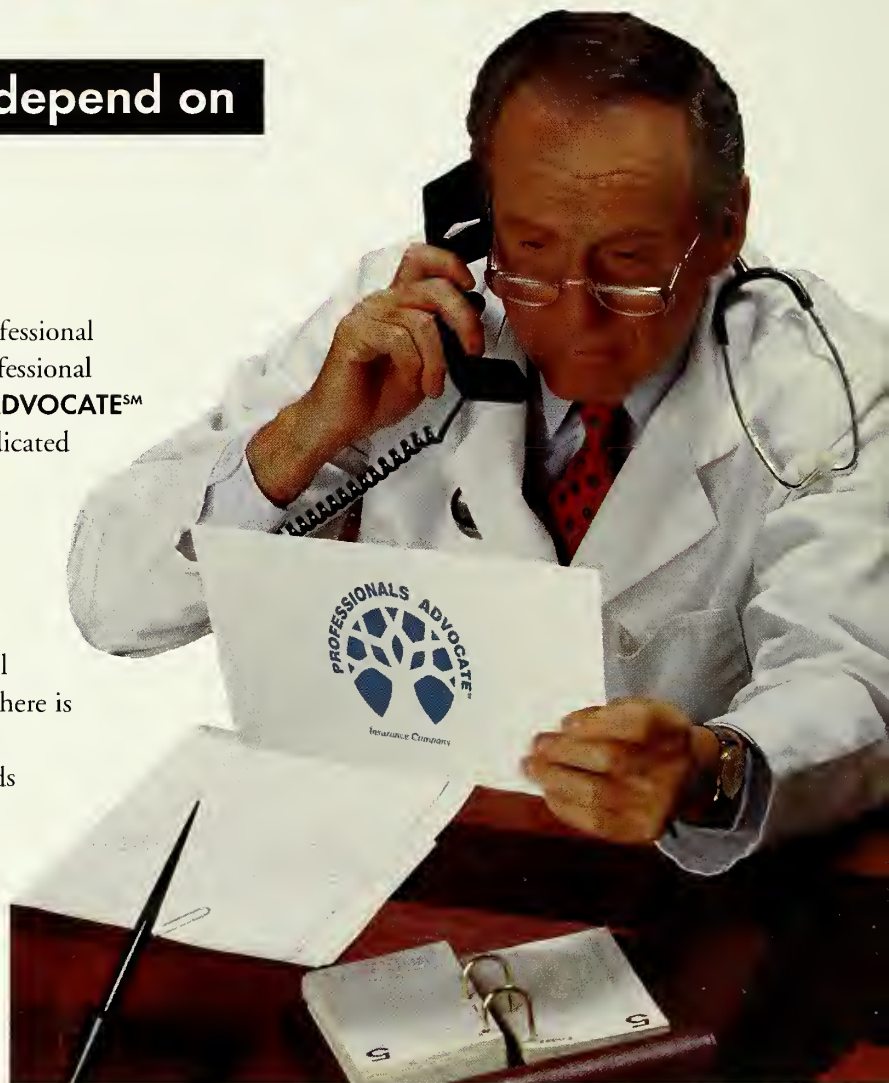
**That's why you should depend on**

## PROFESSIONALS ADVOCATE<sup>SM</sup>

If you want to make the right choice for your professional liability insurance, start by choosing the right professional liability insurance company. **PROFESSIONALS ADVOCATE<sup>SM</sup> (ProAd)** is a physician-owned liability insurer dedicated to the long-term defense of your career.

**ProAd** was founded by one of the oldest and most respected physician-owned and directed liability insurance companies in the country. This legacy gives us a solid foundation of financial resources, stability and experience. And, because there is direct physician involvement in the decisions that affect you, we are sensitive to the special needs of physicians and have a genuine commitment to protecting your reputation and practice.

Let **ProAd** be your advocate. Call today for additional information and a no-obligation quotation from a **ProAd** Agent conveniently located near you.



## The ProAd Advantage

- Quality coverage for all specialties at competitive prices from a financially stable physician-owned insurer.
- Free Tail coverage upon your full retirement with no age requirement, following one full year of continuous claims-made coverage with **ProAd**.
- Absolute Consent to Settle provision.
- New Practitioner discount.
- Full Prior Acts Coverage available.
- Aggressive claims defense policy. Top local attorneys specializing in medical malpractice defense.
- Defendant's reimbursement coverage. All covered attorney fees and defense-related expenses associated with the investigation paid by **ProAd**.
- Prompt and responsive service.
- Knowledgeable local agents selected for their health care expertise.
- MedGuard Defense Coverage with a limit of \$25,000 for defense of administrative or judicial proceedings included at no additional charge.



*Insurance Company*

**Professionals Advocate<sup>SM</sup>**

[www.weinsuredocs.com](http://www.weinsuredocs.com)

Arkansas Agent: Rebsamen Insurance  
1500 Riverfront Drive, P.O. Box 3198  
Little Rock, AR 72203  
501-661-4800 • 501-666-9592 Fax

# CONTENTS

## FEATURES

### 405 Healing Honduras — Medical Missionaries Tell Their Stories

*In some parts of the world, medicine and health care are not as available as they are in the United States, and unfortunately, many inhabitants of poverty-stricken villages have never seen a doctor. Instead, they must depend on the voluntary efforts of doctors like Dr. Bill Scurlock and Dr. Fred Nagel. Here, both doctors share with The Journal the stories behind their medical missions in Honduras and their love of helping the less fortunate.*

### 410 Juggling Careers

*If watching "ER" episodes doesn't satisfy your craving for adrenaline and excitement, just ask Dr. Marvin Leibovich if you can watch his life for a while. Not only is he the director of an emergency department, but Dr. Leibovich is also a Little Rock Police SWAT officer.*

### 420 Common Urologic Problems in Children

*Our special article examines common urologic problems in children. We provide primary physicians with appropriate guidelines for evaluation and referrals. The problems will be discussed in two parts. This month's Part I will cover urinary tract infections, voiding dysfunctions, hematuria and proteinuria.*

## DEPARTMENTS

### 401 Commentary

*William Ackerman, MD*

### 403 What We've Done For You Lately

### 412 Loss Prevention

### 414 Radiology Report

### 416 Case of the Month

### 418 A Closer Look at Quality

### 422 People + Events

### 426 Arkansas Retreats

### 427 Index to Advertisers

### 428 Volume Index



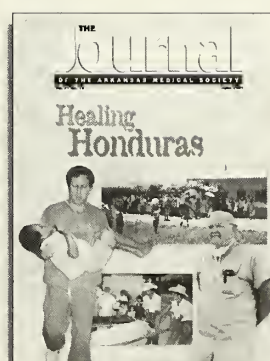
*It's not uncommon for 15 people to live under one roof in Honduras. Physicians Bill Scurlock, Fred Nagel and Charles Lane Jr. share their stories.*

— page 405



*Dr. Marvin Leibovich shares how he wears several hats — that of an emergency room physician and a Little Rock Police officer.*

— page 410



**On the Cover:** Dr. Fred Nagel (left), a family doctor from North Little Rock, carries a sick patient to the clinic site in Trujillo, Honduras. On the right is Dr. Bill Scurlock, a retired surgeon from El Dorado. Like Dr. Nagel, he also did medical missions work in Honduras.

Photos courtesy of Arkansas Democrat-Gazette and Lisa Nagel



# THE ROAD TO ANTIBIOTIC RESISTANCE

Act 12

ENTER STAGE LEFT .....

Antibiotic (solo):

See me, world, for who I am ... I'm a  
dedicated fighter against bacteria.

BUT I'M NOT INVINCIBLE!

Oh how I wish I could, but I simply  
can't cure every illness.

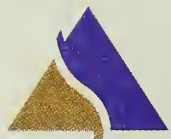
I HAVE LIMITS!

I'm powerless against viruses -  
colds and coughs. I don't work.

The virus is a villain that must  
be allowed to run its course.

OH WORLD, SEE ME FOR WHO I AM!!!!

EXIT STAGE RIGHT .....



Arkansas Foundation  
for Medical Care

Save the Antibiotic.  
Don't use it when you don't need it.



COMMUNICATIONS COORDINATOR  
Judy Hicks

EXECUTIVE VICE PRESIDENT  
Kenneth LaMastus, CAE

ASSISTANT EXECUTIVE VICE PRESIDENT  
David Wroten

#### EDITORIAL BOARD

Sue Chambers, MD	Pediatrics
Joseph M. Beck, II, MD	Oncology
Lee Abel, MD	Internal Medicine
Samuel Landrum, MD	Surgery
Jerry Kendall, MD	Family Practice
William Ackerman, MD	Anesthesiology

#### EDITOR EMERITUS

Alfred Kahn Jr., MD

#### ARKANSAS MEDICAL SOCIETY 2000-2001 OFFICERS

Gerald A. Stolz, Jr., MD, Russellville  
*President*

Joe Stallings, MD, Jonesboro  
*President-elect*

Paul A. Wallick, MD, Monticello  
*Vice President*

Lloyd G. Langston, MD, Pine Bluff  
*Immediate Past President*

Carlton L. Chambers, III, MD, Harrison/Little Rock  
*Secretary*

Dwight M. Williams, MD, Paragould  
*Treasurer*

Anna Redman, MD, Pine Bluff  
*Speaker, House of Delegates*

Kevin Beavers, MD, Russellville  
*Vice Speaker, House of Delegates*

Joseph M. Beck, II, MD, Little Rock  
*Chairman of the Council*

Established 1890. Owned and edited by the Arkansas Medical Society and published under the direction of the Council.

**Advertising Information:** Contact Stephanie Hopkins, P.O. Box 3686, Little Rock, AR 72203; (501) 372-2816.

**Postmaster:** Send address changes to: *The Journal of the Arkansas Medical Society*, P. O. Box 55088, Little Rock, Arkansas 72215-5088.

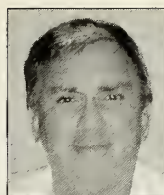
**Subscription rate:** \$30.00 annually for domestic; \$40.00, foreign. Single issue \$3.00.

**The Journal of the Arkansas Medical Society** (ISSN 0004-1858) is published monthly by the Arkansas Medical Society, #10 Corporate Hill Drive, Suite 300, Little Rock, Arkansas 72205. Printed by The Ovid Bell Press, Inc., Fulton, Missouri 65251. Periodicals postage is paid at Little Rock, Arkansas, and at additional mailing offices.

Articles and advertisements published in *The Journal* are for the interest of its readers and do not represent the official position or endorsement of *The Journal* or the Arkansas Medical Society. *The Journal* reserves the right to make the final decision on all content and advertisements.

Copyright 2001 by the Arkansas Medical Society.

## COMMENTARY



# Can Business and Science Coexist in This Century?

By WILLIAM ACKERMAN, MD

**P**enicillin is an effective antibiotic that has a wide margin of safety. Many derivatives of penicillin have been synthesized since its discovery by manipulation of its basic structure. The story of penicillin's discovery is a model for biomedical progress.

In 1929, Flemming was working with staphylococcus variants. On his laboratory bench he set aside a number of culture plates. The plates were exposed to air and were contaminated with various microorganisms. Flemming noticed that a contaminating mold would cause lysis of some of the staphylococcus colonies. Flemming published the results of his findings in the *British Journal of Experimental Pathology* in 1929.

After the discovery of the antibiotic properties by Flemming, the compound was dormant for a decade until further biochemical studies were done by Florey and the age of chemotherapy was discovered.

This story exemplifies Pasteur's saying: "That in research chance prepares only the prepared mind." Louis Pasteur discovered a method to stop milk from spoiling. Both the scientific and lay communities thought that these discoveries were admirable. Today things have changed. There is an increasing feeling that science and business should not mix. There appears to be a feeling in Washington that the art of scientific discovery is tainted if driven by profit.

Rep. Marion Berry from Arkansas is a pharmaceutical company critic. Rep. Berry alleges that some drug companies overcharge patients who need a certain medication. "I think what they're doing is immoral and it should be illegal," Berry said.

Mylan labs recently settled a lawsuit for \$100 million for alleged price gouging. On the other hand, many pharmaceutical companies furnish free medications to those individuals who require a specific drug but are unable to afford it.

President George W. Bush promised to provide drug coverage to the elderly and disabled under Medicare. The congressional budget office underestimated by one-third the amount needed to pay for proposed Medicare drug benefits. As a result, it will be more difficult for Congress to pay for drug benefits.

Many pharmaceutical companies are publicly owned and are in business to make a profit for their shareholders. Developing drugs is expensive. Research and development costs average about \$500 million for each new drug developed in the United States. If drug companies are to continue to develop new drugs they must make enough profit to meet the costs of the drugs that are effective, but also meet the costs of the drugs that are not effective.

The underlying debate between some legislators and drug companies is the terms on which scientific knowledge can be owned. Any pharmaceutical company that owns a patent on a particular drug is held to rigorous standards in order to obtain that patent. Should the financial incentive for developing new medicines be eliminated or decreased? Is it better to have a new expensive drug or no drug at all? Should the federal government subsidize pharmacologic research? There are no easy answers to any of these questions.

The Pharmaceutical Research and Manufacturers of America favor a federal subsidy program that would help needy individuals pay for insurance that would cover the cost of an individual's drugs. Rep. Berry is skeptical that this plan would work. He said representatives from insurance companies have said that such a plan is not workable. Insurance only works when a small number of policy holders collect on their policies, they said.

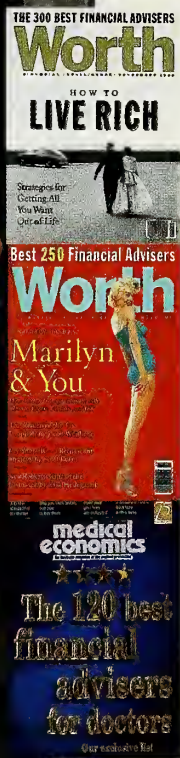
It is obvious that both the lawmakers and the pharmaceutical companies must make some compromises as to what is ethical and what is unethical when science and business are partners. We as physicians should be aware of the costs of medications that we prescribe. We should prescribe medications with attention to both cost and efficacy. We should furthermore document those instances where a patient is unable to obtain a medication that the physician deems is medically necessary. These cases should be reported to the Arkansas Medical Society, who in turn should report this information to the American Medical Association. These statistics could be useful for the establishment of a drug subsidy program that might actually work. ■



Two of the best financial planners in the nation are in Arkansas.

**CINDY CONGER**  
MBA, CPA/PFS, CFP

**RICK ADKINS**  
MBA, CFP, ChFC



They can be found at The Arkansas Financial Group.

Since 1985, we've been helping busy people make smart financial decisions. So next time you're looking for objective answers to life's crucial financial decisions, call The Arkansas Financial Group. You'll be in great company.

Here's what the editors of *Worth* and *Medical Economics* had to say:

*"The Best 150 Financial Advisers for Doctors, 8/00"*

*"The Best 250 Financial Advisers, 9/99"*

*"The Best 300 Financial Advisers, 9/98"*

*"The Best 250 Financial Advisers, 10/97"*

*"The 120 Best Financial Advisers for Doctors, 7/27/98"*

*"Fee-only, objective, customized, comprehensive, affordable advice"*

**The Arkansas  
Financial Group, Inc.**  
**376-9051**

PHOTO: KELLY QUINN/TERRITORIAL RESTORATION

## Collect Bad Debt

- Cheaper
- Faster
- In compliance with the Law

**We Collect  
Arkansas**

If you've always used a collection agency... WHY?

Cut out the collection agency by retaining the Maggio Law Firm.

Save time. Save money.  
Be in compliance with the law.

Have you always used a collection agency because "that's the way you've always done it?"

*Try a new way... tip the scales in your favor, call today.*

# MAGGIO LAW FIRM

your collection law firm

Offices in Conway and Searcy • 1-800-600-3201

[www.ebaddebt.com](http://www.ebaddebt.com)



## New Service Allows Physicians to "Connect" With Their Patients

By DAVID WROTEN

**T**he use of Internet technology continues to grow, especially as a means of communication and a source of information. For instance, do a search for asthma on any search engine and you'll find thousands of Web sites. Unfortunately, though, no one is out there ensuring that the information on these sites is clinically valid. This gives new meaning to the old adage, "let the buyer beware."

Make no mistake, your patients are using these Web sites to learn more about their medical conditions, treatment, and even to self-diagnose. The Arkansas Medical Society believes that physicians can play a significant role in pointing their patients toward medical information that they can trust. And now, the AMS has the tool to help physicians fulfill that role and use the Internet to communicate "securely" with their patients. It's called "Medem."

Medem is a secure online physician network founded by seven national medical specialty societies and the American Medical Association. It offers secure messaging, access to reliable health information and customized physician Web sites. In April, the Arkansas Medical Society became the 27th medical society to join the Medem partnership.

What is a "secure online physician network"? Through Medem, AMS members can communicate confidential information to their patients over a secure Web site, ensuring that the information will remain confidential. Patients will be able to request prescription refills and test results, schedule appointments and get medical care information 24 hours a day, seven days a week. Not only can this be a valuable service to patients, but it also has the potential to create efficiencies for the office staff.

How about the asthma search mentioned earlier? The Medem network will provide patients with the most credible, trustworthy and high quality health information on the Internet. How can I say that? Simple, the information will come from, or be approved by, the nationally recognized medical societies that make up Medem. For example, I believe I could place a high degree of trust in clinical information from the American Academy of Pediatrics — a Medem founder. Or how about the American College of Allergy, Asthma & Immunology? Another Medem founding organization.

What's more, patients will access this information and the secure messaging through their physician's own Web site built by Medem. Patients will go to "their doctor" for health information, a feature that is designed to build a stronger patient-physician relationship and help solidify the physician's role in providing accurate, reliable medical information.

So, what have we done for you lately? Through this partnership with Medem, AMS members have an opportunity to build their own Web site for communicating effectively and confidentially with their patients, which can also be accessed by those patients for the most current and credible medical information available on the Internet.

This is indeed an exciting opportunity for Arkansas physicians. Even better, it's being offered free to members of the Arkansas Medical Society. Now that's a member benefit!

To learn more about Medem, visit the AMS Web site at [www.arkmed.org](http://www.arkmed.org), or go directly to the Medem Web site at [www.medem.com](http://www.medem.com). ■

### Air Force Healthcare. Good Pay. Professional Respect.

#### That's Why No One Comes Close.

Experience the best of everything: best facilities, best benefits. Outstanding opportunities for travel, 30 days of vacation with pay, training and advancement.

For an information packet, call  
**1-800-423-USAF**  
or visit  
**[www.airforce.com](http://www.airforce.com)**.



**U.S. AIR FORCE**

### Looking for a temporary place to call home?

- Fully equipped kitchen
- Non-smoking and handicapped suites
- Outdoor swimming pool, SportCourt and fitness room
- Pets are welcome

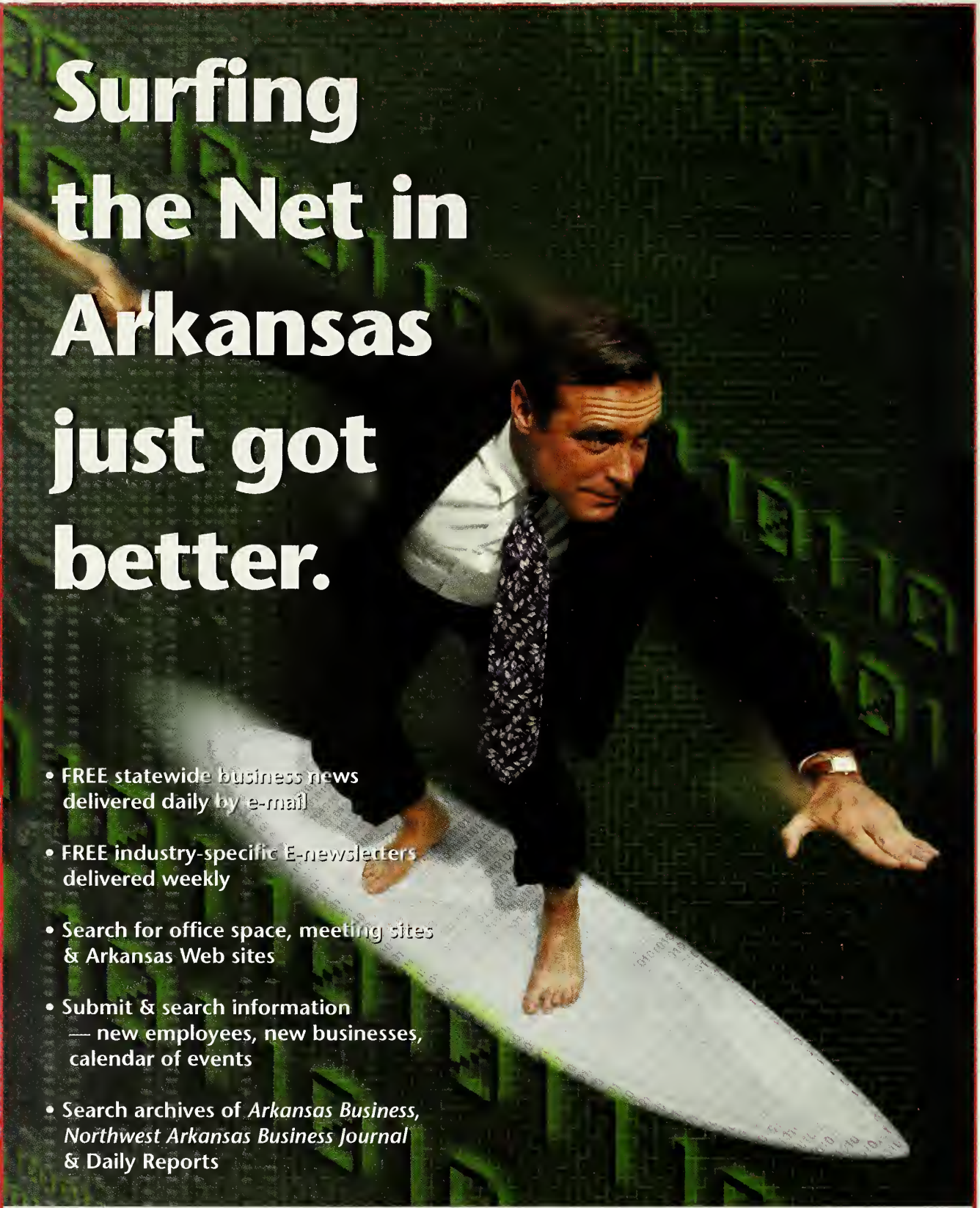


**Room to relax,  
room to work,  
room to breathe.**

1401 Schackelford Rd. • 501-312-0200  
Reservations: 1-800-331-3131



# Surfing the Net in Arkansas just got better.

A man in a dark suit, white shirt, and patterned tie is surfing on a white surfboard. He is leaning forward with his arms outstretched for balance. The background is dark with green binary code (0s and 1s) floating around, suggesting a digital or internet theme.

- FREE statewide business news delivered daily by e-mail
- FREE industry-specific E-newsletters delivered weekly
- Search for office space, meeting sites & Arkansas Web sites
- Submit & search information — new employees, new businesses, calendar of events
- Search archives of *Arkansas Business*, *Northwest Arkansas Business Journal* & Daily Reports

The State's **#1**  
Source for  
**Arkansas**  
Business Information



ARKANSAS  
BUSINESS.COM

For sponsorship opportunities, contact Jeff Hankins  
at 372-1443 or [jhankins@abpg.com](mailto:jhankins@abpg.com)



# a higher calling

## Arkansas Doctors Lend a Helping Hand to Hondurans



Photo courtesy of Arkansas Democrat-Gazette

By SHELBY BREWER

IF YOU'RE LOOKING FOR A SURE WAY TO MAKE PEOPLE SMILE, JUST MENTION THE WORD VACATION. PEOPLE CAN'T HELP BUT SMILE AS IMAGES OF SANDY, WHITE BEACHES AND TROPICAL DRINKS WITH TINY UMBRELLAS DANCE THROUGH THEIR MIND.

**N**ow mention a vacation with extremely hot weather, no air conditioning, no electricity, long hours, crowded and unsanitary conditions and miles of sick people. More than likely, you won't get the same happy expression.

But the doctors who spend their vacations laboring under these conditions smile. And they'll tell you it's the best vacation they've ever had.

These doctors are known as medical missionaries. They don't take classes on how to be a missionary, and their skill levels aren't necessarily higher than other doctors. Instead, these medical missionaries are just your regular, everyday doctors who've decided to use their medical abilities to help the less fortunate.

The reasons why these doctors are hooked on spending their vacations, as well as their own money, in poverty-stricken countries vary.

For instance, Dr. Charles Lane Jr.'s reason is one that's close to his heart. A retired otolaryngologist in Fort Smith, Dr. Lane was about



Photo courtesy of Arkansas Democrat-Gazette

to retire in 1986 when suddenly he felt there was something else left to do. His feeling took him all the way to India and St. Vincent Island in the southern part of the Caribbean, where he completed many surgeries. After those two trips, the 81-year-old decided it was time to end his mission work and retire for good.

But his wife's death in December 1993 changed all that. "I think God laid it into my heart to get back into mission work," he said.

Only a few months later in 1994, Dr. Lane received some mail about the World Medical Mission, an organization which sends doctors across the world to witness to Christ and do medical mission work.

*Top photo: The plane carrying medical equipment for Dr. Bill Scurlock and his surgical team comes in for a landing on a mountain in Honduras. Far right: Patients wait in the crowded and unsanitary hospital in Trujillo, Honduras. Bottom left: Dr. Scurlock talks to patients awaiting surgery in Gualcinse, Honduras, where he has done medical mission work for 20 years.*





Photo by Lisa Nagel

**FACES OF POVERTY** — Shown here is a typical one-room house in Trujillo, Honduras, where a mother and her 13 children live. Dr. Fred Nagel and his wife, Lisa Nagel, return to this village each year to perform medical mission work.

After applying, he received a call two weeks later requesting an otolaryngologist in Papua New Guinea.

"After that, I was totally convinced that God wanted me to get back into mission work," he said. Dr. Lane eventually made five trips to Papua New Guinea and said it was one of the greatest experiences of his life.

"It's been one of the ways God has shown me a reason for my wife's death," he said. "I've been one of the fortunate individuals to see a real reason why the Lord took her."

Like Dr. Lane, other doctors have also felt a calling to become medical missionaries. Here are the stories of two such doctors who have humbly made a difference in the lives of thousands.

### Mission Gualcinse

It was after sunset nearly 20 years ago when Dr. Bill Scurlock rode a mule into the small, remote village of Gualcinse in western Honduras. There was no electricity and the town was dark. Accompanied by his surgical team — two anesthetists, two scrub nurses, an automobile mechanic and a Louisiana state trooper — Dr. Scurlock had traveled from El Dorado, Ark., for a very important reason — to operate on thousands of sick Hondurans, most of whom had never seen a doctor in their lives.

For almost two decades, the 67-year-old

retired surgeon has been doing volunteer mission work, and was recently honored for it with the Ethel K. Millar Award for Religion and Social Awareness given by Hendrix College in Conway, his alma mater.

Dr. Scurlock's been to such countries as Siberia, Russia, Africa, Haiti and Mexico, but his real story, he said, is Honduras.

Dr. Scurlock learned of Gualcinse's need for a surgeon from an American missionary who was already living there. The missionary had issued an urgent plea to the United States for surgeons, so Dr. Scurlock gathered up a team of volunteers from the El Dorado area and boarded a plane.

Once the team arrived in Gualcinse, they unloaded their equipment into a stucco-mud building with dirt floors. This served as the clinic where the team would perform surgeries. Dr. Scurlock said he didn't sleep much that first night, particularly because there was a war going on with Nicaragua at the time and it was in their area.

At dawn, he opened the board window and was shocked at what he saw. "There was a solid line of humanity that extended all the way down the street with every conceivable surgical problem you can imagine," he said. These were the patients the missionary had scheduled for surgery.

The team quickly improvised two operating rooms. In one room, they used the

fog light of an automobile hooked to a car battery and powered by a small, gasoline generator for light. In the other room, they used a table from the local Catholic church and a flashlight. The instruments were sterilized in a pressure cooker over an open fire, and the anesthesia machine, which had been dismantled and brought in pieces, was reassembled by the light of a kerosene lantern. The mechanic and state trooper served as the surgical assistants. Neither had been in an operating room before.

Dr. Scurlock said the team did 70 operations that week, ranging from hysterectomies, hernia repairs, mastectomies, removal of ovarian tumors and operations for congenital defects. Patients were brought in on stretchers as far as eight miles away, he said.

When they left 10 days later, Dr. Scurlock said the line of people waiting for surgeries was still just as long.

### A Need So Great

What made that first trip so special to Dr. Scurlock is that he learned a valuable lesson from one of the Hondurans — one that he will never forget. He has since shared this story with many people, including Peter Jennings on ABC's "World News Tonight" in hopes that it will raise awareness of the need for doctors in Third World countries.





Top photo: Dr. Bill Scurlock and his wife treat a patient in Gualcinse, Honduras. Bottom: Dr. Fred Nagel talks to a young patient before examining her. He said one of the rewards of doing mission work is developing relationships with the patients.

"I examined a man with far advanced cancer on his abdomen that was inoperable. So with my limited Spanish, I told him, 'Sir, you came too late.'

"And he looked up at me and replied, 'No sir, I've been here all my life. You came too late.'"

After hearing those words, Dr. Scurlock promised himself that he would come back to the village every year, and he has done so for the past 20 years.

Dr. Scurlock said he's proud of what he and other volunteers from the El Dorado area have accomplished in two decades. I've done more than 500 operations there without a single complication, he said, and that's with no blood, X-rays or laboratory facilities. In addition, the volunteers have built a dam and waterline to provide clean water, constructed a concrete building to do surgeries and built five churches.

On his final trip to Honduras last year, Dr. Scurlock said as he was riding the bus into the village, he saw what he thought was a mirage.

"There was a big, 12-room hospital with a modern pharmacy, operating room, laboratory and a \$50,000 generator given by the country of Spain," he said. "So in 20 years, we've gone from a mud hut to a fairly modern hospital."

Dr. Scurlock said he became interested in mission work when he was in the army.

"I was in the Vietnam War and was drafted out of practice, and I saw that these Third World countries have no access to surgery."

Dr. Scurlock laughs when he describes his first medical missions trip, or rather, attempted trip. When he got out of the army,



Photo by Lisa Nagel

he and other doctors drove to Mexico in the late 1970s and turned a school bus into an operating room, but country officials quickly ran them out. "They thought we were drug dealers," he said.

When asked why he enjoys medical missions work, his answer is quite simple — because it's refreshing, he said.

"When we were in medical school, we all had one desire — and that's to cure the world and do good," he explained. "But then when you get into practice, over a period of time, things change and other factors move in. Then you've got the business side of it, the legal side, the government intervention and the paperwork. In mission work, you do what you wanted in the first place — a one-on-one doctor/patient relationship where the patient has full confidence in you."

Dr. Scurlock said it cost him about \$800 for each trip and he had to use his vacation time, but that didn't bother him.

"There's no better or more relaxing way to take a vacation than to do that work. I know that sounds funny, but it's true. Go to Florida and you'll forget the trip, but go to Honduras and you'll remember it for the rest of your life."

## Mission Trujillo

For Dr. Fred Nagel, a 45-year-old family doctor at North Little Rock Family Practice, the real vacation starts once the mission trip is over.

"I think mission trips put things in perspective," he said. "As busy as you think you are here, when you go on a missions trip, you work much harder and it drains you physically and emotionally. So when you come back it's like a vacation — your patients are all nicely scheduled ... you have air conditioning."

But despite the hard work, Dr. Nagel wouldn't think twice about going on another missions trip. In fact, he just returned from a missions trip in March and is already planning one for next year.

Dr. Nagel became involved in missions work five years ago when he and his wife went on a missions trip to Trujillo, Honduras, with other members of their church, Christ the King Catholic Church. Since then, he's gone on every mission with the church group and he and his wife, Lisa Nagel, a nurse practitioner, are now the directors of the mission.

Their mission is divided into several parts, he said, including evangelization, construction and medical. The medical part of the mission includes a hospital and three clinics — medical, eye and dental — situated in outlying villages.

The volunteers are divided and assigned to a site based on their skills or professions. For example, three surgeons work at the hospital site while three primary care physicians work at the medical clinic.

"We see about 1,000 patients during the week at each site," Dr. Nagel said. "Since the first mission five years ago, they've seen 6,000 patients."

The group takes prepackaged medicine in a dose form with them so they don't have to waste time sorting out pills there, he said.

About 90 people with a variety of professions from the church participate each year, he said. Their mission lasts seven days with two days for travel, and the travel can be pretty strenuous, he said. For example, once the group gets off the airplane at San Pedro Sula, they must then ride a bus for six hours



## Audio, Visual Equipment for Your Home or Office.



**ONLINE**  
TECHNOLOGIES INC  
SINCE 1985

10307 Maumelle Blvd  
NLR, AR 72213  
224-3906 • 1-800-687-4647  
www.onltech.com

## ST. VINCENT HEALTH SYSTEM

### •OB/GYN •CARDIOLOGY •HOSPITALIST

Actively searching for  
physicians to practice in Little  
Rock. If you have an interest  
or know someone interested  
in an opportunity, please  
contact Faye G. Stewart at  
St. Vincent Health System.  
(501) 660-3245 or  
1-800-482-1288 ext. 3245

† CATHOLIC HEALTH  
INITIATIVES

**St. Vincent  
Health System**

INTENSIVE CARING.

[www.stvincenthealth.com](http://www.stvincenthealth.com)

on a bumpy, dirt road to Trujillo — and it's a very dusty journey, he said. In fact, the dust is so bad that they must wear masks to avoid inhaling it, mainly because the eggs of parasites live in the dust, which is why a majority of the Hondurans have worms.

Treating patients with worms was often routine for Dr. Nagel.

"I was in the back of the building seeing a patient when all of a sudden I heard a lot of commotion in the waiting room, so I went to see what it was about. Standing there was a little girl, about 7 years old, who had just coughed up a worm. It was squirming around on the floor next to her and it was big, like the size of a fishing worm. Everyone had cleared away from her. So we captured it and brought it back in a jar of alcohol to show the people at church that the stories you hear about people getting worms are true."

Besides hook worms and round worms, other conditions that were prominent among the villagers included malaria, diarrhea, malnutrition, skin infections, fungal infections, denque fever and chagas fever.

The challenge, he said, was trying to treat these patients with little or no diagnostic testing. "And on top of that, it's complicated by our unfamiliarity of these tropical diseases — sometimes we've only read about them in our medical text as students."

In addition, Dr. Nagel said many of the children are born with congenital defects, cerebral palsy and other deformities — some of which the doctors can do nothing about. However, the surgeons have done miraculous work on the children by repairing such deformities as cleft lips and palette, orthopedic injuries and club feet, he said.

### A Different World

Dr. Nagel said most of the families are extremely large, having six to 14 children. He remembers seeing a young mother walking barefoot while carrying both a baby and an older child with a deformity.

A lot of families from surrounding villages would walk three to four hours to the clinics because it's their only shot at medical care.

The typical family housing was a thatched-roofed hut with clay walls, usually having just one room with no electricity or water. Dr. Nagel said the village's hospital, where the volunteer surgeons worked, was very unsanitary and in total disrepair, and on their first trip they discovered all the toilets were backed up and the smell was unbearable. So the first thing the volunteers did was put in a sewage system. They also brought a big generator to supply the hospital with electricity, and they refurbished two

operating rooms. Each year, the group also donates equipment to the hospital, such as a sterilizer, anesthesia machine and EKG monitor.

Each day of the mission, the volunteers would have mass at 6 a.m. followed by breakfast. They'd open the clinics at 8 a.m. and work until 5 p.m. Dr. Nagel said the challenge was to get the most critically ill seen first.

"You can't see everybody, and it feels like you're just able to do very little," he said. "It's just a minor drop in the ocean compared to the overall scheme."

Another obstacle, he said, is that the volunteers are only able to offer short-term solutions to long-term problems.

"We can give them vitamins and treatment for parasites, but the vitamins will run out and the parasites will come back, so we try to offer them something more long term in the form of patient education. We teach them things like personal hygiene, water purification and sanitation, safe food preparation, and we give them things like soap, toothbrushes and baking soda."

Overall, Dr. Nagel said the missions have made him a better person. "It makes you appreciate all you've been blessed with. It puts things into perspective so that you don't get as wrapped up in materialism as so much of us tend to do."

He said meeting the Hondurans has also been an eye-opener to him.

"It makes you realize that Americans, interestingly enough, are the ones you should pity, when you think it would be just the opposite, because Americans are lost in the way they live. They live too fast to enjoy life; they're too wrapped up in money, materialism and other worries," he said. "You'd think that these people who have nothing and are starving would be depressed, but they're the happiest people I've ever seen. They always have a smile on their face, and they're so appreciative of what you do for them."

Dr. Nagel said there are several rewards from doing mission work. "Probably the best is treating a patient that you've seen before to see how you've helped them," he said. And since the church group returns to Trujillo each year, Dr. Nagel said he's developed relationships with the locals and considers them his friends.

"It's certainly not for everybody," he said. "I think there is a calling for it, just like there is a calling to be in medicine, but I also think it's an obligation. We're given so many gifts and blessings that we should share with other people we have a duty to help those who are less fortunate." ■



# Arkansas Medical Society Insurance Programs....



## AMS BENEFITS, INC.

A wholly owned subsidiary of the  
Arkansas Medical Society

P.O. Box 55088

Little Rock, Arkansas 72215-5088

(501)224-8967

WATS 1-800-542-1058

FAX (501) 224-6489

"Available products include group  
health, office package, professional  
liability, home, auto, and more."

*tailor-made for physicians*

Insurance products are a fact of life. You can buy them almost anywhere. Fortunately there's one agency that only represents physicians...Arkansas physicians. AMS Benefits, with products to meet both your professional and personal needs.

Call us at 1-800-542-1058 or 501-224-8967



# Meet Our Members

## Marvin Leibovich, MD

By SHELBY BREWER

*It's 3 a.m. and the phone rings. It's the emergency room. There's been a bad wreck on the interstate, and three people are severely injured. While throwing on your white coat, you jump into the car and race to the hospital. But on the way there your pager goes off. It's your SWAT commander. A riot broke out at a bar, and they need you at the scene in case someone gets hurt.*

**F**or most doctors, this lifestyle probably seems like a nightmare, but for Dr. Marvin Leibovich, it's a dream come true — and he's living that dream today.

You see, not only is Dr. Leibovich the medical director of the Emergency Trauma Department at Baptist Health Medical Center, but he's also a member of the Little Rock Police SWAT Team.

He never planned on having two careers, though, especially not a career in medicine. "When I was in college, I was going to be an attorney. And unfortunately, I was born beautiful instead of wealthy," Dr. Leibovich said, laughing, "so I had to work."

"I got a job working in the ER at a hospital in Memphis back in 1966, and I always caught myself looking in the back because that's where all the action was. So I asked the head nurse if I could be an orderly so I could work back there, and I fell in love with it."

He changed his major to premed, specialized in emergency medicine and never looked back.

"I'm very glad I chose medicine. It's a great career and I'm always thrilled with the excitement of the emergency department."

You would think that the heart-pounding excitement of an emergency room would be enough for Dr. Leibovich, but apparently not. When one of his patients offered him another adrenaline-filled job, he jumped at the chance.

"One of the officers on the team, Danny Sabo, came into the emergency department as a patient. We got to talking and he said, 'You know, we could really use a doctor on the team.' It sounded interesting and fun, so I went to training a week later, and I've been with them ever since."

As a member of the SWAT team, Dr. Leibovich's primary mission is to provide medical support for the team members and be ready to treat any injuries should they occur. He said it only makes sense for a doctor to be on the SWAT team.

"We send physicians to basketball and football games, but there's certainly no more dangerous situation than a tactical police operation where you've got a barricaded suspect professing he's going to kill anyone who tries to take him alive."

So how does he juggle both careers? "Very easily," he said. "I think a good emergency physician should be able to practice his skills just as comfortably in the field as he does in the emergency department."

And he does just that. As medical director of the emergency trauma department, Dr. Leibovich works closely with the administration to develop policies and procedures, but he also works as a full-time emergency physician. He rides with the SWAT team one night a week, trains with them two days a month and goes on all the SWAT call-outs.

Fortunately, he said, he's been able to balance the two careers because of the support he's received from his co-workers.

"I've got some great partners, and they've been able to cover me so that I can get away in a quick period of time if I'm called out," he said.

He drives a SWAT car to work, which has his gear, guns and uniform already in it so that whenever he's paged, all he has to do is walk out the door.

The 54-year-old doctor has been on the SWAT team since 1992, and since then he's been involved in several drug raids and riots and has taken care of people who have been shot or injured. But he's most proud of what he has done for each individual team member.

*Dr. Leibovich, a Little Rock Police SWAT officer, prepares for a possible drug bust with his team.*

Photo: Mark Wilson



"I've worked up a medical form for each member of the team, and we keep it in our SWAT van so that if one of the officers is ever injured, I've got all his medical background information, routine medication and drug allergies with me. I also participate in their physical fitness training program and give them input with that. Basically, I try to ensure the health of each member. I've kind of become a family doctor to them."

When comparing his two jobs, Dr. Leibovich said they have a lot in common. "In emergency medicine, there's no typical day. There's an awful lot of stop and go. It goes back and forth between minor illnesses that really don't need to be treated in an emergency department to major trauma, and that's the parallel to police work. Sometimes it can be boring, boring, boring, but then all of a sudden someone comes in with a knife stuck in his chest."

Another common aspect of the two careers is that you have to be an adrenaline junkie to be successful, he said.

"And that's my personality. I'm an adrenaline junkie. My police work takes

that adrenaline another step higher," he said. "There's a certain magic to being the only person there at 3 a.m. when someone wanders through the door who's been shot in the chest, and you have to make instantaneous, life-saving decisions."

Dr. Leibovich said that although there are a lot of heartaches involved with emergency medicine, the rewards make it all worth it. "The real reward is knowing that there are people alive who otherwise might have perished had you not been there to provide immediate interventions," he said.

One of the challenges of his work, however, is dealing with patients who sometimes abuse the emergency department. "Unfortunately, there are some patients we get to know very well. We call them the repeat offenders," he said. "They come in 10-15 times a year. The other day we had a lady call the ambulance because her foot hurt."

He said emergency departments across the United States are in critical condition right now. "They're overcrowded, there's not enough staffing and we get in a gridlock situation here. At any one time, several hospitals in Little Rock may be on

diversion for all ambulance traffic because their hospital is out of critical care beds, the emergency department is completely full and doctors are treating people in the hallways.

"The challenges are both to be able to provide excellent patient satisfaction at a time when there is increased demand and workload for the staff," he continued, "and ensuring that every patient has received quality emergency care."

In addition to serving as medical director, Dr. Leibovich is also responsible for developing the Med Flight Program at Baptist, and he regularly makes helicopter flights to trauma scenes.

Dr. Leibovich has been working at Baptist Medical Center since 1978. He received his undergraduate degree from Memphis State University and medical degree from Meharry Medical College in Nashville, Tenn. He completed a rotating internship at the University of Arkansas for Medical Sciences in Little Rock.

In his spare time, Dr. Leibovich likes to run — about eight to 12 miles every other morning — and spend time with his wife and four sons. ■

## Since our roots are firmly established in Central Arkansas, we thought it would be a good idea to grow a new branch.

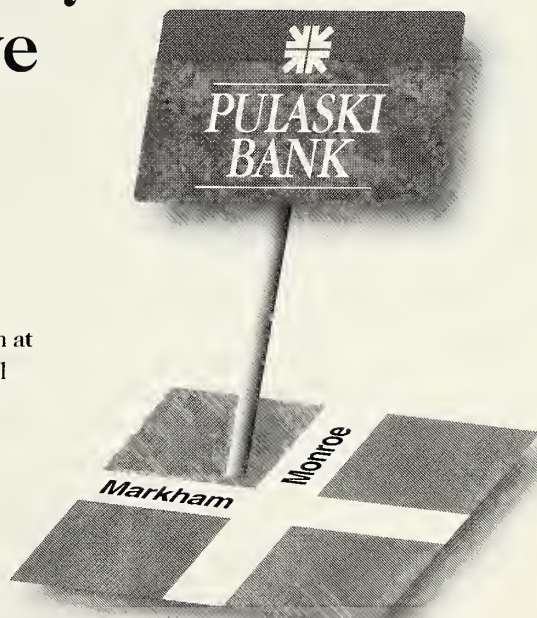
We're growing to meet the needs of our customers, and our new branch at Markham and Monroe is a perfect example. Opening this summer, we'll have a new full service location to meet all of your needs.

If you're looking for a bank that puts the customer first, check out Pulaski Bank. Our roots run deep in Central Arkansas, and now we're making it easier for you to bank with us.



**PULASKI  
BANK**

MEMBER FDIC



4900 W. Markham (Opening Soon!) • Pierce at "R" Street, 661-7748

Third at Broadway, 661-7842 • 65th at University, 661-7879

14309 Cantrell (Westside Plaza), 661-7793 • 4600 JFK Boulevard, 661-7320

Rodney Parham at Shackleford, 661-7891 • 11100 Financial Centre Parkway, 661-7373

Hwy. 107 at Kiehl Ave. (ATM Only) • UAMS, (ATM Only)





# Postoperative Care — Inattentive Approach

J. KELLEY AVERY, MD

In cases of this type, time and time again it appears that the highest standard of care was maintained during the operation, but the postoperative care was not up to the expected standard.

## Case Report

A 17-year-old unmarried woman who had experienced an entirely uneventful prenatal course began to have labor about a week later than her calculated due date. On examination, her physician, a board certified Ob/Gyn, found her fetus to be presenting in the breech position. Indications for the surgery were that the woman was nulliparous at the end of her 41st week of gestation, and that the baby was a breech presentation. The presenting part remained high after two hours of good labor, and a cesarean section was recommended and carried out, resulting in the delivery of a 6 pound 7 ounce female infant with APGAR scores of 10 and 10. About two hours after the delivery, the patient began shaking uncontrollably, and the nurses said in the notes that she "demanded something to stop the shaking" and that she was "easily upset and crying." The physician was notified and ordered blood work for early morning.

The patient's admission WBC count had been 15,300/cu mm with 76% neutrophils, not unusual for this time in gestation, but the results of the work done about three hours after delivery was WBC count 25,200/cu mm with 95% neutrophils (bands 16%). This was postoperative day one. She continued to complain bitterly of pain, and was described in the nursing notes as "Patient hysterical/crying."

The physician ordered an intravenous broad spectrum antibiotic, Mefoxin. Blood cultures were ordered X 2. Tylenol was given for pain and the shaking. At midnight the temperature was recorded at 101.4°F. The dressing was removed and the wound was said to be "healing well." That morning she was moving about some and seemed to be having less pain, but by the afternoon of day two she complained of severe right shoulder and back pain. The Mefoxin was increased from 1 gm every eight hours to 2 gm, and Clindamycin 600 mg every six hours IV was added.

In the late afternoon the patient began to complain more of pain and her abdomen was found by the nurses to be "hard and distended." On walking, she expelled some gas from the "stomach" with some relief of pain. Just before midnight the dressing was removed and the skin around the wound was found to be red. Temperature remained 101.2°F. Two hours later the patient vomited, and the dressing was found to be stained with a considerable amount of foul-smelling, greenish-brown liquid. The physician was notified and ordered more narcotic for the pain. This was the third postoperative day.

The foul-smelling drainage continued in increasing amounts. An enema gave "fair results." X-rays of the chest and abdomen were ordered. The patient was made aware of the tests that had been done and the X-rays that had been ordered. She was also told that the physician would come and examine her and discuss the laboratory findings. The patient did not want family called at this time. The progress note indicated that the foul smelling liquid drainage continued and that the abdomen appeared softer but still distended.

The X-rays reported some free air under the diaphragm, which was not considered abnormal for this time after surgery. However, the film of the abdomen showed multiple fluid levels and suggested to the radiologist that intestinal obstruction might be present, but he added that it could be due to a sustained ileus after surgery. Mid-morning stat laboratory results showed WBC count of 15,400/cu mm with 82% neutrophils and 8% bands. The potassium was reported as 3.2 mEq/L.

A progress note by the attending physician, "Open surgical wound and clean," was entered in the record. A consent form was signed and the attending physician took the patient to surgery, opened the wound and irrigated it with copious amounts of saline and Ringer's solution. The incision was left open to heal by secondary intention. The operative note stated that the

fascia was found to be intact except for a small defect at the left extremity of the lower abdominal incision.

The patient continued to vomit following debridement and the attending physician asked for a surgical consultation "in the AM regarding ileus." An attempt was made to rectify the electrolyte imbalance, particularly in view of the persistent hypokalemia. The patient continued to vomit. She was responsive but having severe pain in the abdomen. Late on the fourth postoperative day Gentamycin was added to the intravenous antibiotic regimen.

The surgical consultant reviewed the case in his note and speculated that the hypokalemia was contributing to the ileus. His opinion was that the patient had an intra-abdominal abscess. He suggested an aggressive attempt to correct the potassium level. This was attempted for the next 12 hours. When the surgeon changed the dressing the next morning, greenish liquid and gas were escaping from the abdomen, which suggested the presence of a small bowel fistula with obstruction, and he transferred the patient to the medical center.

At the medical center the patient was explored again, disclosing severe suppurative peritonitis, a small bowel perforation and some necrosis of the abdominal wall in the region of the initial transverse incision. The perforation was closed and the abdominal wound was packed open to heal secondarily. Early in her stay in the hospital in the medical center, she developed severe adult respiratory distress syndrome and required tracheal intubation for about two months with aggressive medical and nutritional support. She was in the medical center hospital for about five months. She suffered severe neurologic deficits, both motor and sensory, which largely cleared with time and extensive and intensive physical therapy.

A lawsuit was filed charging the attending physician with negligence in injuring the bowel at the time of the cesarean section and failing to detect and treat the injury in a timely manner.

This patient had medical expenses of about \$500,000 by the time she was discharged from the medical center hospital. The amount of the settlement is confidential but it can be said that the lawsuit was for an amount far in excess of this physician's policy limits, but settlement was reached within that limit.

### **Loss Prevention Comments**

In cases of this type, time and time again it appears that the highest standard of care was maintained during the operation, but the postoperative care was not up to the expected standard. In this case under the expected standard of care the injury to the bowel would have been discovered earlier, perhaps 48 hours earlier. Injury to adjacent structures during an operation is not, in itself, a deviation from the standard of care. With the best of techniques and in the finest of hospitals, this type of injury occurs. Usually it is discovered immediately after the fact, and corrective action taken. Even when it is not discovered immediately and when the record supports careful postoperative scrutiny, the complication is found early enough to take remedial action and avoid serious injury to the patient. It is when the record of the postoperative care suggests inattention to detail, failure to listen to the patient's complaints, and slow response to symptoms of the complication, that the physician can be adjudged negligent in a court trial.

In this case, there was suggestive evidence of problems as early as the first postoperative day. The patient was experiencing inordinate pain for the type surgery she had. The nurses talked in their notes of "hysteria and crying" as if to dismiss the patient's complaints. There was some fever, not unusual in the early postoperative period, but the marked elevation of the WBC count and the marked shift to the left in the differential should have been a high index of suspicion that things were not going well in this patient's abdomen. Severe pain persisted and late in the second day

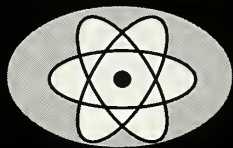
there was some redness and edema around the incision and over the pubic area. This should have warranted a more vigorous response from the attending physician. The appearance of foul copious drainage on the third day after the operation and the nursing note that described "gas from the stomach" should have been thoroughly investigated. Was the gas coming from the rectum or the "stomach? The answer to this question probably would have called for front abdominal exploration. This occurred during heavy antibiotic coverage, and certainly meant that the caregivers were dealing with more than a skin infection at the operative site. At this point if there had been an aggressive surgical response, with opening of the incision including the peritoneum, the injury to the small bowel would have been discovered and repaired, leading to recovery with only a few extra days of hospitalization.

It was the delay in exploration of the abdomen that led to the life-threatening complications that occurred later: the adult respiratory distress syndrome, the necrotizing myofascitis of the abdominal wall, the cortical injury both cognitive and motor and the prolonged hospitalization. One could take the position that this patient is extremely lucky to be alive, and that is true, but it was the failure to observe carefully the postoperative course that threatened her life in the first place. The operation is not over when the patient gets back to her room. It requires the continued attention of the physicians to the complaints and daily progress of the patient. When all that goes well in the postoperative period, then, and only then, is the surgery over. ■

*Reprinted from a February 2000 issue of Tennessee Medicine. The Case of the Month is taken from actual Tennessee closed claims. An attempt is made to fictionalize the material in order to make it less easy to identify. If you recognize your own case, please be assured that it is presented solely for the purpose of emphasizing the issues presented.*



# RADIOLOGY



## Posterior Dislocation of the Shoulder is Uncommon, Hard to Diagnose

AUTHORS: Ronald Walker, MD — John O. Bethel, MD

AUTHOR/EDITOR: Steven R. Nokes, MD



**Figure 1a.** AP shoulder

### History

A 50-year-old male presented to the emergency room with shoulder pain and restricted motion after reaching to turn off his alarm clock in the morning. A shoulder series was ordered (Figure 1a & b) followed by a CT Scan (Figure 2).

### Findings

The AP view reveals internal rotation of the humeral head, a positive rim sign and a trough line. The first two are indirect signs of a posterior shoulder dislocation. The scapular Y-view demonstrates posterior displacement of the humeral head, which lies beneath the acromion. The CT Scan confirms posterior dislocation of the humerus with a J-shaped defect in the medial anterior humeral head, with the posterior margin of the defect perched against the posterior glenoid.

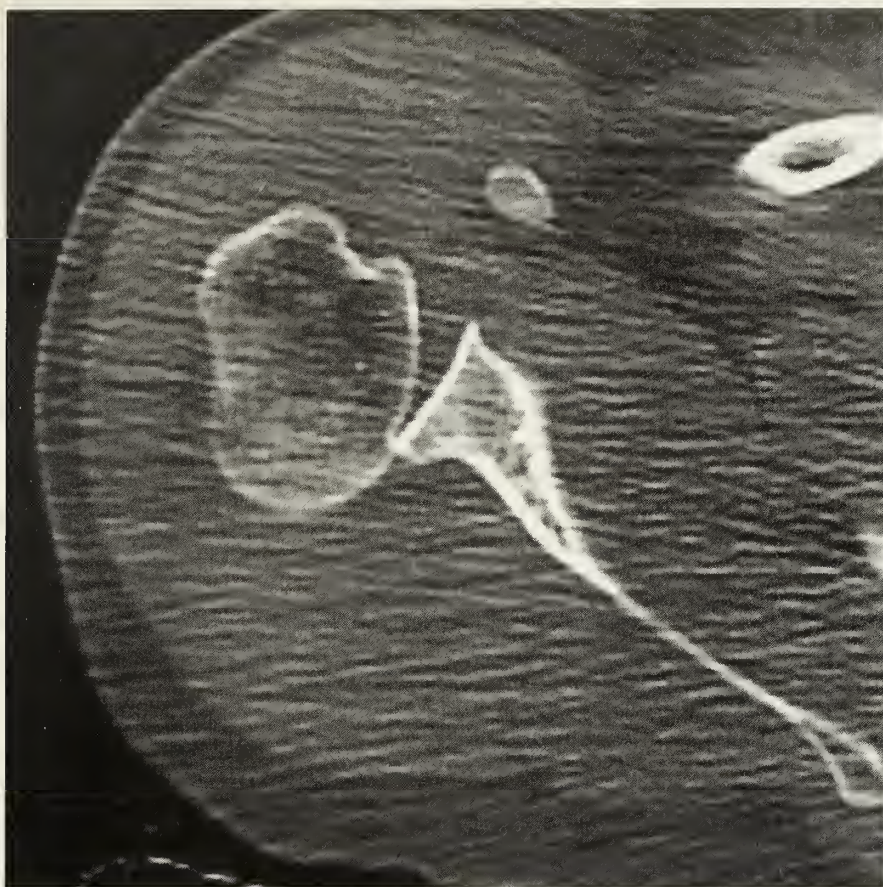
### Discussion

The primary difficulty with posterior dislocation of the shoulder is in making the diagnosis. Over half of the cases are missed at the initial examination, with delay in diagnosis of weeks to months. The continued pain and limited motion are often misinterpreted as adhesive capsulitis or a frozen shoulder, making this a common source of litigation.

Multiple factors contribute to overlooking this injury. Posterior dislocation of the shoulder is uncommon, accounting for only 3% of shoulder dislocations. The findings on conventional radiographs are often subtle and indirect. Lastly, the physician may identify a lesser tuberosity fracture



**Figure 1b.** Scapular Y-view



**Figure 2.** CT Scan of the shoulder

and fail to detect the underlying dislocation (satisfaction of search).

Convulsive seizures are the most common course of posterior shoulder dislocation, followed by direct trauma. A small percentage of cases are spontaneous, as in our case.

The radiographic findings of posterior shoulder dislocation are subtle on the anterior posterior view, which is usually sufficient to diagnose traumatic shoulder injuries. Fixed internal rotation is always present. When the humeral head is posteriorly dislocated, it is pushed laterally by the posterior glenoid, producing apparent widening of the joint space. A distance of greater than 6 mm from the medial humeral head to the anterior glenoid rim is termed the "rim sign." This distance is 10 mm in the case (figure 1a). The "trough line" may be the only specific indication of the posterior dislocation on the AP view. This is an additional line running vertically through the medial humeral head corresponding to the trough-like impaction fracture.

If detected early, posterior dislocation is treated satisfactorily with simple reduction in the absence of a posterior glenoid fracture. A CT is mandatory to exclude this. When a delay in diagnosis occurs, surgery is usually required because the capsule is stretched and the humeral head defect enlarges with time. ■

*Drs. Walker and Nokes are with the Radiology Consultants of Little Rock. Dr. Bethel is the director of emergency medicine at Baptist Memorial Medical Center in North Little Rock.*

#### References

1. Arndt, J.H., Scars A.D. Posterior dislocation of the shoulder. *AJR* 1965, 94:639.
2. Cisternino, S.T., Rogers, L.F., S51. Stufflebaum, B.C., Konglik, A.D. The trough line: a radiographic sign of posterior shoulder dislocation. *AJR* 1978, 130:951.
3. Rogers, L.F. *Radiology of Skeletal Trauma* 2nd edition, Churchill, Livingstone, Inc. 1992, 732-740.

## ARCHITECTURE

FOR YOUR MEDICAL NEEDS

1 800 764 ASTI



**William Henry Asti, AIA**  
architects, economists, development consultants

B u y — S e l l  
L e a s e — R e n t



The Med-Plus Group is a B2B website that helps medical facilities find the best prices available on New, Used, and Refurbished medical

equipment. With over 500 dealers, suppliers and manufacturers to select from, we have the solutions to meet your needs. In addition, we offer our customers flexible lease options to finance their purchase. Visit us on-line today or call Mike South or Rick Wooldridge for more information.



**MedPlusQuotes**

**Healthcare Resources**

(800) 643-0944 Fax (501) 224-0930  
www.medplusquotes.com  
email: JRW@medplusquotes.com  
MLS@medplusquotes.com





## Nasal Meningioma: Report of One Case and Review

DAVID L. HATFIELD, MD — MARK WHITE, MD — C. ARAOZ, MD

### Abstract

A case of primary nasal meningioma in a 69-year-old woman is described. The pathologic, radiologic and clinical characteristics are described. A summary of previously published articles on the subject is given.

### History

The patient is a 69-year-old female who presented with complaints of right sided nasal obstruction for several months duration. She had no complaint of pain, bleeding or drainage related to her nose. She had non specific complaints of headaches for years. Her past history is remarkable for adenocarcinoma of the lung with metastatic disease to the low neck nodes which had been treated with in the year prior to her presentation with chemotherapy. Her history also included excision of a parathyroid adenoma and thyroid gland for benign disease.

Physical findings included a large polypoid grayish-red mass which filled the right nasal cavity anteriorly except for a small portion along the floor of the nostril.

### Radiology

CT scan in the coronal plane demonstrated a mass extending from the medial superior nasal cavity in the area of the cribriform plate displacing the middle and inferior turbinates laterally. The ethmoid bulla was also opacified but did not appear to be contiguous with the mass. No intracranial lesions were seen and the bone of the base of the skull was intact. (Figures 1 and 2).

### Preoperative Diagnosis

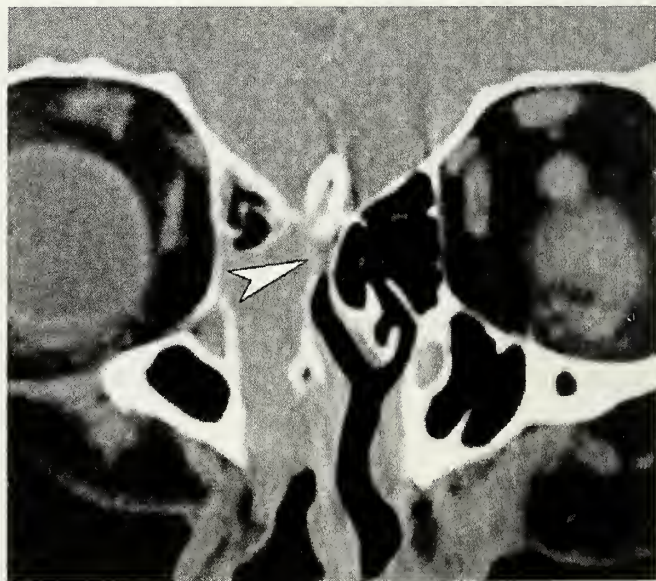
Intranasal mass with chronic ethmoid and maxillary sinusitis.

### Operative Findings

Under general anesthesia, endoscopic evaluation revealed that the mass was firm and mobile. A needle aspiration yielded no fluid or blood. A biopsy of the mass was obtained and following frozen section the entire mass was resected via the intranasal route with endoscopic guidance. The mass was found to be attached to the anterior base of the skull medial to the



**Figure 1.** Coronal CT section demonstrates right nasal cavity mass displacing middle turbinate (black arrow) and inferior turbinate (white arrowhead).



**Figure 2.** Mass causes partial erosion of perpendicular plate (white arrowhead).



middle turbinate where the perpendicular plate of the ethmoid fuses with the skull base. Minimal bleeding was encountered. No CSF leak was produced. The patient was discharged from the outpatient facility and made an uneventful recovery. During a follow up period of more than eight months no recurrence has been discovered.

### Pathology

The diagnosis was intranasal meningioma. The tumor was covered by respiratory mucosa. The immuno-reactivity of the tumor cells was positive for epithelial membrane antibody. The cells did not react with desmin, cytokeratins, S-100 and factor VIII antibodies.

### Discussion


Extracranial meningiomas have been documented in the ear, temporal bones, skin, orbit and paranasal sinuses. Some of these cases represent direct extension from an intracranial meningioma. Reviews by Ho<sup>1</sup>, Perzin<sup>2</sup> and Taxy<sup>3</sup> published in 1980, 1984 and 1990, respectively, examined true primary nasal and paranasal sinus meningiomas. The cumulative total of published cases by various authors is about 30 cases. A recent review by Thompson LD and Gyure KA from the Armed Forces Institute of Pathology<sup>4</sup> found 14 intranasal meningiomas between 1972 and 1992.

Nasal meningiomas have occurred at all ages with the

mean at about 47.6 years. Some series show a female predominance of 2.5:1. The pathogenesis of intranasal meningiomas is uncertain. They are thought to arise from cells of the arachnoid villi which were pinched off during embryonal development at ectopic sites. Presenting symptoms of nasal meningiomas include nasal obstruction, epistaxis, sinusitis, pain, mass, nasal discharge, or rarely, anosmia. Nasal meningiomas are almost always benign, but they can cause damage to surrounding structures by mass effect or erosion through bone. Complete surgical excision is the treatment of choice. Recurrence is rare but can occur from incomplete excision. Complications of surgical excision include CSF leak, blindness, double vision, bleeding and anosmia. ■

### References

1. Ilo, K.L. Primary meningiomas of the nasal cavity and paranasal sinuses. *Cancer* 1980;46: 1442-7.
2. Perzin, K.H. Pushparaj, N. Non-epithelial tumors of the nasal cavity, paranasal sinuses, and nasopharynx: a clinicopathologic study *Cancer* 1984; 54: 1860-9.
3. Taxy, K.H. Meningioma of the paranasal sinuses. *American Journal of Surgical Pathology* 1990; 14: 82-6.
4. Thompson, L.D., Gyure, K.D. Extracranial sinonasal tract meningiomas; a clinicopathologic study of thirty cases with a review of the literature. *American Journal of Surgical Pathology* 2000 May-, 24(5): 640-50.



*Introducing the*

**DIAMOND STAR**

**Fast: 147 Knots / 169 MPH**

**Affordable: Ownership from 25% to 100%**

**And Fun!!!**

**CENTRAL**  
FLYING SERVICE

Call Bob Rollins  
501-975-9394

**SKYSHARE**

**DO YOU SUFFER  
FROM TRANSCRIPTION  
OVERLOAD?**

## HEALTH DATA SERVICES

*a medical information  
management company*

Dictate to our toll free  
number **TODAY** and  
receive your transcribed  
documents in your email  
**TOMORROW.**

**1-800-866-8218**  
Call Today



# Enhancing Patient Safety Preoperative Antibiotic Prophylaxis

BY DONNA S. WEST, RPH, PHD,  
WILLIAM E. GOLDEN, MD AND  
NENA SANCHEZ, MS

Postoperative wound infections occur in approximately 5% of all patients who undergo surgery, costing the health care system an additional \$1 billion annually.<sup>1,2</sup> Fortunately using prophylactic antibiotics prior to surgery has been shown to reduce postoperative infections. More specifically, the timely administration of prophylactic antibiotics within two hours before the initial incision can reduce the risk of infection, resulting in reduced length of hospital stays and reduced hospital costs.

In an effort to improve patient safety in Arkansas, AFMC has been conducting a quality improvement project focusing on the appropriate use of perioperative antibiotics. Of specific interest was the

administration and timing of the initial antibiotic dose.

A retrospective chart review was conducted. Five hundred sixty-nine cases involving hip replacement surgery, knee replacement surgery, or aortofemoral popliteal bypass/other vascular shunt surgery were randomly selected from 37 hospitals statewide. In all three surgical procedures, antimicrobial prophylaxis is needed. Data regarding surgical start times and the timing and administration of antibiotics were abstracted from the patient charts. Of the 569 cases, 531 cases met the denominator criteria.

The results indicated that approximately 80% of patients received prophylactic antibiotics within the two-hour time window, as shown in Table 1. Alternatively, this success rate can be stated as a failure rate. Of the selected patients, 20% did not receive antibiotic therapy within the two-hour window: 10% failed to receive any prophylactic

antibiotic and 10% failed to receive the prophylactic antibiotic within the two-hour window.

Quality improvement initiatives often follow a S-shaped curve; thus, improving the last 10 or 20% is often difficult. However, efforts need to be made to increase the timely administration of prophylactic antibiotics.

The results reveal areas where the process of administering prophylactic antibiotics can be improved. For example, prophylactic antibiotics administered on the wards were more likely to fall outside of the two-hour window. Table 2 provides the average time between the administration of the prophylactic antibiotic and the initial incision, based on the location of administration. It is evident that the probability of receiving prophylactic antibiotic therapy within the two-hour time period is greatest when given in the operating room.

**Table 1: Rates of Antimicrobial Prophylaxis within Two-Hour Window**

Procedure	N	Compliance	(%)
Hip or Knee Replacement	332	276	(83.1)
Aortofemoral Popliteal Bypass/ Other Vascular Shunt/Bypass	199	150	(79.4)
<b>Total</b>	<b>531</b>	<b>426</b>	<b>(80.2)</b>

Arkansas Foundation for Medical Care (AFMC) is the Peer Review and Quality Improvement Organization for Medicare and Medicaid in Arkansas. AFMC works collaboratively with providers, community groups and other stakeholders to promote the quality of care in Arkansas through evaluation and education. For more information about AFMC quality improvement projects, call 800-272-5528, ext. 204.

**Table 2: Rates of Antimicrobial Prophylaxis Within Two-Hour Window Based on Location of Administration**

Location of Administration	Rate within Two-Hour Window If Pre-op Antibiotic Given
OR	96.63%
ER	83.33%
OR Holding	88.10%
Ward	64.29%

These results support the quality standards of the Infectious Disease Society of America published in *Clinical Infectious Diseases* as well as other antibiotic prophylaxis guidelines.<sup>3</sup> Several solutions designed to deliver prophylactic antibiotics in a more timely fashion have been recommended, as stated below.<sup>4</sup>

**"Each hospital (should) set up a system that makes someone responsible for making certain that antibiotics are given at a certain time in a routine fashion.... Assigning the circulating nurse to check the box and make sure it has been done will ensure that it will happen."**<sup>4</sup>

Likewise, it has been recommended that prophylactic antibiotics for surgery be dispensed directly to the anesthesiologist or CRNA and have the anesthesiologist deliver the antibiotic as part of the routine patient care. Administration of prophylactic antibiotics on the patient wards should be eliminated.

The study results also provide insight into the types of antibiotics being used for antimicrobial prophylaxis. Not surprising, cefazolin was used in 71% of cases receiving antibiotics, which is in compliance with perioperative antibiotic guidelines.<sup>5,6,7</sup> The most troubling result was the number of patients who received vancomycin as a routine order for antimicrobial prophylaxis. Approximately 11% (61 cases) received vancomycin. Of

these 61 cases, 64% (39 cases) received vancomycin because of a routine order. For seven (11%) of these cases, vancomycin was given because of patient allergy or to target against resistant organisms; and for 12 (20%) of the cases, the reason vancomycin was given is unknown.

Textbooks, guidelines and journal

---

*It has been recommended that prophylactic antibiotics for surgery be dispensed directly to the anesthesiologist or CRNA and have the anesthesiologist deliver the antibiotic as part of the routine patient care. Administration of prophylactic antibiotics on the patient wards should be eliminated.*

---

articles warn that first-line drugs such as the fluoroquinolones, third-generation cephalosporins, imipenem and vancomycin should not be used for prophylaxis because this may compromise their effectiveness in treatment.<sup>6,7,8</sup> First- or second-generation cephalosporins have been shown to be effective in

prophylaxis, and the more potent first-line agents should be reserved for use as treatment of presumed or established infection. It is recommended that hospitals reevaluate their use of vancomycin as a standard order for antimicrobial prophylaxis.

Overall, increasing the timeliness and appropriateness of antibiotic prophylaxis in surgical procedures will reduce postoperative wound infection rates and lower health care costs. Targeted interventions regarding the timing of the use of prophylactic antibiotics is likely to reduce wound infections, resulting in improved patient care and decreased health care costs. As health care professionals focus on patient safety, system improvements in all areas, including antimicrobial prophylaxis in surgery, will be necessary. ■

#### References:

1. Gottrup F. Prevention of Surgical Wound Infections (editorial). *N Engl J Med* 2000; 342(3): 202-203.
2. Wenzel RP. Preoperative Antibiotic Prophylaxis (editorial). *N Engl J Med* 1992; 326:337-339.
3. Infectious Diseases Society of America. Quality Standard for Antimicrobial Prophylaxis in Surgical Procedures. *Clin Infect Dis* 1994; 18(3): 422-427.
4. Panel Discussion. Current Trends in Antibiotic Prophylaxis in Surgery. *Surgery* 2000; 128: S14-S18.
5. ASHP Commission on Therapeutics. ASHP Therapeutic Guidelines on Antimicrobial Prophylaxis in Surgery. *Am J Health-Syst Pharm* 1999; 56: 1839-1881.
6. Page CP, Bohnen J, Fletcher R, McManus AT, Solomkin JS, Wittman DH. Antimicrobial Prophylaxis for Surgical Wounds. *Arch Surg* 1993; 128:79-88.
7. Woods RK and Patchen D. Current Guidelines for Antibiotic Prophylaxis of Surgical Wounds. *Am Family Physician* 1998; Available at <http://www.aafp.org/afp/980600ap/woods.html>, Accessed 7-28-2000.
8. Centers for Disease Control and Prevention. Guidelines for Prevention of Surgical Site Infection. *Am J Infect Control* 1999; 27(2): 97-132.



# Common Urologic Problems In Children: Guides To Evaluation And Referral, Part I

JOHN F. REDMAN, MD — PRAMOD P. REDDY, MD

## Abstract

A discussion of common urologic problems in children is presented to provide primary physicians with appropriate guidelines for evaluation and referrals. The problems will be discussed in two parts: Part I will cover urinary tract infections, voiding dysfunctions, hematuria and proteinuria. Part II will cover abnormalities found on antenatal renal ultrasonography, hypospadias and other penile anomalies, phimosis, undescended testes, inguinal hernia and hydrocele, and varicoceles.

An adage states: "The questions in medicine never change over time — only the answers." Certainly the busy primary care physician may experience the frustration of changing evaluation guidelines established by narrow subspecialties. Guidelines for the evaluation of children with disorders of the genitourinary tract are no exception. The following presentation will address some of the most common childhood urologic problems with a brief discussion of how to evaluate and when to refer for pediatric urologic consultation or management.



## Urinary Tract Infections

By the broadest definition, urinary tract infections would include infections of the kidneys, bladder and urethra. The most common infections are those caused by bacteria. Usual symptoms include dysuria, frequency, urgency, daytime wetting, suprapubic discomfort, flank discomfort and fever. Although all of these symptoms may be associated with a urinary tract infection, a child may have all of these symptoms and not have an infection of the urinary tract. Further, young children and infants may have urinary tract infections and have no symptoms directly attributable to the urinary tract.

The key to diagnosis is the urinalysis. The urinalysis, however, is only valid if the urine submitted for analysis has been collected in such a manner as to preclude contamination. The easiest collection is in circumcised males who are old enough to void on command. If urethral complaints are present, it is useful to have the boy, in addition to collecting a mid-stream specimen, collect the initial 10cc to obtain a urethral wash. An uncircum-

cised male should retract the prepuce to the extent that the meatus is uncovered. With boys too young to void on command, the genitalia may be cleansed and the urine collected in an adhering plastic bag (wee-bag). Bagged urine specimens, however, are frequently unreliable because of bacterial contamination.

Atraumatic catheterization using a small infant feeding tube (5-8F) may be required to assure an uncontaminated collection.

In infants, a suprapubic aspiration of the bladder may be performed to avoid catheterization if questions remain regarding the adequacy of the collection.

In girls who are able to void on command, there is seldom a reason to resort to the use of a catheter to obtain urine for examination and culture. A helpful technique is to have the child sit astride the commode with the mother kneeling beside her. The mother separates the child's labia and collects the specimen in mid-stream. The technique may result in wetting of the hands and floor, but the accuracy of the collection is confirmed by the mother so that any abnormal finding will not later be attributed to a less than optimal collection. In girls unable to void on command, an adhering plastic collection bag may be utilized. However, if an abnormal urinalysis results, it should be confirmed by catheterization using a small infant feeding tube (5 or 8F). Although a reagent-impregnated test strip is helpful in screening for bacteria and pyuria, a microscopic examination of the centrifuged sediment should be performed for confirmation.

In a child with a properly obtained urine specimen, any bacteria is significant. The finding of pyuria and bacteria confirms a urinary tract infection. Whether bacteria are noted or not, with pyuria, the urine should be submitted for culture. If a child has signs or symptoms indicative of a urinary tract infection, the urine should probably be cultured since small amounts of bacteria may be missed with urinalysis alone.

Occasionally bacteria without pyuria will be found, which may indicate colonization but not an infection. It is incalculable, however, how many girls are treated and evaluated for urinary tract infections, unnecessarily, based on the findings from improperly collected urine specimens.

Any child with an initial documented urinary tract infection is deserving of an evaluation, which should include ultrasonography of the kidneys and bladder and a voiding cystogram. All males should be evaluated with a contrast voiding cystourethrogram. In females the initial cystogram may be done using contrast media or a radiopharmaceutical agent.

### **When to refer**

The primary reasons to consider referral are the findings of anatomic abnormalities of the urinary collecting structures or vesicoureteral reflux. Although children with the lesser grades of reflux are usually managed medically, many primary care physicians still prefer at least an individualized or case-by-case opinion regarding an appropriate regimen for management. If an initial referral has not been sought, it should be strongly considered if the child has break-through infections on maintenance antimicrobial prophylaxis.

### **Voiding dysfunctions**

There are a myriad of manifestations of childhood voiding dysfunctions including nocturnal enuresis, diurnal and nocturnal enuresis, frequency, urgency, infrequent voiding and intermittency of the urinary stream. There is also a wide range of ages when children normally have attained both daytime and nighttime urinary continence. At age 4 the majority of children will have daytime and nighttime continence. However, by age 5, 10-15% of children may still have nocturnal enuresis.

For children presenting with symptoms of voiding dysfunction, a screening urinalysis can be a timesaver. If the urine shows bacteria and pyuria on a well-collected clean catch aliquot, the child should be evaluated as in the case of any child with a urinary tract infection. If the urine is clear microscopically, a further history should be obtained to include, in addition to urinary complaints, a bowel history, particularly that of constipation and/or encopresis.

In boys the urethral meatus should be examined. In both boys and girls a history should be obtained regarding a small urinary stream, straining with voiding, or infrequent voiding. In all children the skin over the lumbar spine, sacrum and coccyx should be inspected for signs of an underlying spinal dysraphism, such as deep dimpling or a patch of hair. All children brought to the attention of a physician with a voiding dysfunction should undergo an ultrasound examination of the kidneys and bladder.

### **When to refer**

Referrals should be done at any point that the physician is unclear as to the diagnosis of a voiding dysfunction, does not have a management plan or the child is not responding to a management format. Children with an abnormal renal and bladder ultrasound examination should be referred.

### **Hematuria**

Hematuria may be gross or microscopic. A frequent concern

of primary care physicians is the finding of blood in the course of a routine urinalysis as part of a well-child examination. One of the most common concerns is a colorimetric change indicating the presence of blood on one of the commercial test strips. Often this finding is of little consequence. However, it should be confirmed with a microscopic examination of the sediment obtained by centrifuging the urine. If blood is identified microscopically, then further evaluation should be by an ultrasound examination of the kidneys and bladder. An excretory urogram (IVP) and endoscopy of the bladder are not necessary in children in the initial evaluation of hematuria.

Gross hematuria should be evaluated by careful examination of the centrifuged urine sediment to look for casts and bacteria. The history of the actual visualization of blood in the act of voiding is important in boys, that is, was the blood noted at the first, the last or all through the stream? Blood noted at the first and the last of the stream suggests a urethral site for the bleeding. Other important points in the history are the presence or absence of clots and the color of the urine, whether dark, bright red, maroon or brown. Discomfort with voiding may be an important fact as well as a history of any pain associated with the onset of hematuria. These signs and symptoms alone may not be significant, but coupled with other findings may aid in establishing a correct diagnosis. A child with gross hematuria also should be evaluated with ultrasonography of the kidneys and bladder.

### **When to refer**

Hematuria thought to be secondary to renal parenchymal disease may be a reason for referral to a nephrologist if the physician is not sure of the diagnosis or wishes assistance with evaluation and treatment. Patients with calculus disease should be referred for further evaluation regarding etiology of the calculi and especially if there is evidence of obstruction. Any abnormality of the renal parenchyma or collecting structures or bladder noted on ultrasonography should be evaluated by a urologist.

### **Proteinuria**

Proteinuria as an isolated finding should be managed by surveillance. Persistent proteinuria should be evaluated by renal ultrasonography. Proteinuria in the higher ranges (3-4+) particularly when associated with abnormal urine sediments, such as red blood cells and casts, strongly indicates glomerular disease.

### **When to refer**

Children with persistent proteinuria or heavy proteinuria, particularly that associated with abnormal urinary sediments, should be referred to a nephrologist for further recommendations. ■

*Drs. Redman and Reddy are with the department of urology, University of Arkansas College of Medicine and Arkansas Children's Hospital.*



# PEOPLE+EVENTS

## EVENTS

### College of Medicine Alumni Reunion Weekend

The annual College of Medicine Alumni Weekend hosted by the Arkansas Caduceus Club is scheduled for June 8-10 at the Capital and Excelsior hotels in Little Rock. Returning graduates from the following classes may participate: 1936, 1941, 1946, 1951, 1956, 1961, 1966,

1971, 1976, 1981, 1986 and 1991. Activities will kick off with a reception June 8 at the Capital Hotel honoring those who graduated 50 or more years ago. Also that night, the annual awards for Distinguished Alumnus and Distinguished Faculty will be presented at a banquet in the Excelsior Ballroom. Activities on June 9 will include a scientific session on the campus of UAMS, tours of the new facilities, a luncheon and the annual

meeting of the alumni association. In addition, there will be separate dinners for each graduating class at the Capitol and Excelsior hotels that night. Concluding the weekend's activities will be a family brunch on June 10.

More information about the event, as well as nomination forms for the Distinguished Alumnus and Distinguished Faculty awards, may be obtained by calling (501) 686-6684.

## HONORED

### AMA Recognizes Fort Smith Physician as Emerging Leader in Medicine

Dr. Hugh H. Jackson of Fort Smith was among a select group of 50 practicing physicians chosen to participate in an intensive training program designed to sharpen the political and advocacy skills of emerging leaders in medicine. Sponsored by the American

## New Members

Ossama Al-Mefty, MD  
NS - Little Rock

Roger Amick, MD  
P - Little Rock

Elizabeth Armstrong, MD  
GP - McCrory

Paul A. Armstrong, DO  
GS - Van Buren

Samuel H. Arnold, DO  
GS - Hope

Harendra Arora, MD  
AN - Little Rock

Gregory J. Babbe, MD  
FP - College Station

Robert R. Baker, DO  
P - Van Buren

Peter H. Ball, MD  
FP - Fayetteville

Jeffery L. Barber, DO  
FP - Wynne

Bart Barlogie, MD  
ON - Little Rock

Sandeep Bhargava, MD  
GE - Little Rock

Joseph Bissett, MD  
CD - Little Rock

James Bradburn, MD  
OTO - Fort Smith

Daniel Bradford, MD  
HEM - Fayetteville

Nita Brown, MD  
CHP - Russellville

Derek M. Bryant, MD  
FP - Little Rock

Dante R. Burgos, MD  
P - Texarkana

William J. Burt, MD  
FP - Fort Smith

James I. Cagle, MD  
FP - Junction City

Maida P. Campanini, MD  
PD - Hot Springs

Douglas T. Campbell, MD  
PD - West Memphis

Patrick D. Chan, MD  
NS - Searcy

Lori M. Cheney, MD  
IM - Mountain Home

Joel Cobb, MD  
FP Resident - Little Rock

Saladin A. T. Cooper, MD  
OBG - Little Rock

Witold P. Czerwinski, MD  
P - Batesville

David G. Davenport, MD  
DR - Little Rock

Roy E. Denton, MD  
IM - West Memphis

Jonathan Drummond-Webb, MD  
CDS - Little Rock

Uma Duvvuri, MD  
IM - Jonesboro

Vernon L. Eagan Jr., MD  
AN - N. Little Rock

Andrea J. Eberle, MD  
PD - Little Rock

Michelle L. Eckert, MD  
GS - Pine Bluff

Michael A. Eckles, MD  
IM Resident - Little Rock

David M. Evans, MD  
CD - Searcy

Amanda Ferrell, MD  
IM Resident - Little Rock

James W. Fletcher III, MD  
EM - Jonesboro

Jason Foster, MD  
PD - Springdale

James H. France, MD  
U - Conway

Elizabeth A. Frazier, MD  
PDC - Little Rock

Charles M. Friedman, MD  
R - Little Rock

Venkatarama R. Gaddam, MD  
Resident - CD Little Rock

William P. Galli, DO  
IM - Mountain Home

John D. Gaston, MD  
FP - Fayetteville

Sunil Gera, MD  
AN - Jonesboro

Ira Gershner, MD  
IM - N. Little Rock

Gunnar H. Gibson, MD  
D - Little Rock

Stephanie L. Granger, MD  
GS - Little Rock

Russell J. Green, MD  
OM - Lowell

Paula M. Guinnip, MD  
GS - Searcy

Marc Gunter, MD  
OBG - Hot Springs

Arun K. Gupta, MD  
IM - Newport

Holly H. Handloser, MD  
FP - Little Rock

Ali M. Hashmi, MD  
P - Jonesboro

May Hawawini, MD  
PD - Little Rock

Deborah A. Hays, MD  
FP - Fort Smith

Prabhat K. Hebbar, MD  
IM Resident - Little Rock

Medical Association and GlaxoSmith-Kline, the Emerging Leaders Development Program prepares physician leaders to meet the challenges of advancing health policy through the legislative process. Dr. Jackson was selected for the program based on his demonstrated leadership potential, commitment to leadership, participation in organized medicine and diversity of leadership experience. The day-long program was held in conjunction with the AMA's National Leadership Conference March 3-6 in Washington, D.C.



Dr. Jackson

### Arkansas State University Honors Team Physician

Dr. Glenn Dickson, an orthopedic surgeon in Jonesboro and head team physician for Arkansas State University's athletic teams for the past 25 years, was honored for his service to the university during a basketball game Feb. 10. Among the services he provides to the university's athletics programs are physical examinations of the more than 350 student athletes and weekly injury clinics and exams. He is also on call and available when needed by the school. He is an honorary member of the Southwest Athletic Trainers Association.

### Memorial Scholarship Fund Established in Honor of Late Physician

The North Arkansas College Foundation Inc. has established a memorial scholarship in honor of the late Dr. Frederick C. Turner Jr. of Mountain Home. The scholarship will enable a student who has achieved academic excellence to begin or continue his or her postsecondary education. Recipients may pursue any course of study that will result in an associate degree, licensure or certificate. To obtain an application or for more information, contact North Arkansas College's financial aid office at (870) 391-3240.



**ROLEX**

*Lady Oyster Perpetual  
Stainless steel and 18kt. gold  
chronometer with Oyster bracelet.*

*Men's and Midsize  
Oyster Perpetual Datejusts  
Stainless steel and  
18kt. gold chronometers  
with Jubilee bracelets.*



*Official Rolex Jeweler*  
**MARY HEALEY'S**  
 FINE JEWELRY  
*Because You Love The Best*  
 5600 Kavanaugh • Little Rock, AR 72207 • 501-661-1314 • Mon - Sat 10:00 - 5:30  
Rolex, Oyster Perpetual, Datejust and Oyster are trademarks.



### Healthcare Professional Liability Business/Workers' Compensation/ Life & Retirement Planning

Managing the business side of healthcare is time consuming, but FARMERS helps get you back where you belong—delivering quality medical care.

For almost 50 years, Farmers has been a well respected carrier. We provide the highest quality products and services to all types of physician groups. We know our business.

Our professional team has an established background in medical services and management. We are committed to working in our client's best interests, offering premier claims and risk management services—with coverage especially for the physicians.

**A.M. Best rating of A+ (Superior)**



Mark Perry

112 Municipal Drive • Jacksonville, AR 72076  
(501)982-4561 • 1-800-467-2436  
mperry@alltel.net



Joanna Owens

712 A Bradley Dr • Mtn. Home, AR 72653  
(870) 424-2120 • 1-888-424-2120  
baxterinsurance@yahoo.com



## Blues, Barbecue, Botanic Gardens.



Beale Street, Sunset Symphony, Orpheum Theatre and charming southern hospitality make Memphis, Tennessee a wonderful place to call home. Enjoy the laid back lifestyle of working in West Memphis, Arkansas but all the amenities of the largest city in Tennessee.

### Seeking a Leader and a Team Player

**Crittenden Memorial – Emergency Department**  
West Memphis, Arkansas

#### ♦ 110 Per Hour for Full-Time and Part-Time

- ♦ 19,000 Patient Visits Annually in 10 bed Emergency Department
- ♦ Located 10 Minutes from Downtown Memphis
- ♦ Health, Life, Dental, & Retirement Plan Options plus \$2,000 CME
- ♦ Relocation Assistance and Malpractice Insurance with Tail
- ♦ Criteria: BE/BC Primary Care or Emergency Medicine
- ♦ One Staff and One Medical Director Position Available March 1<sup>st</sup>
- ♦ Excellent Monthly Stipend for Medical Director

*Don't Miss Out – Call Now!!*

Jennifer Strouse @ 800-362-2731 ext. 2014

Email: [jennifer\\_strouse@emcare.com](mailto:jennifer_strouse@emcare.com) or Fax your CV to 214-712-2444

An Equal Opportunity Employer

[www.EmCare.com](http://www.EmCare.com)

## Family Practice Opportunity

A Central Arkansas Hospital is seeking a qualified BC/BE Family Practice or Internal Medicine physician to help establish a primary care clinic in a rapidly growing area of Central Arkansas, minutes from Little Rock. The physician will be required to relocate to this bedroom community.

The selected candidate will be the sole physician in the community and will be an instant success. The physician will have a predominately outpatient office practice and Hospitalists are available for inpatient care. Employment is an option.

Qualified candidates should submit their information and CV to the email address below.

- Instant Success
- Bedroom Community
- Minutes from Little Rock
- Solo Practice
- Start-up clinic
- Primarily Outpatient
- Hospitalists Available
- Must Relocate
- Employment Options

*All Contacts are kept Confidential!*  
E-mail Information and Resumes to:  
[jclawren@aol.com](mailto:jclawren@aol.com)

## Pulaski County Medical Society Officers Elected

The Pulaski County Medical Society recently elected Dr. Anthony D. Johnson, a general pediatrics practitioner with the Arkansas Pediatric Clinic, as its new president. Other officers include Dr. David E. Bourne, president-elect; Dr. Denise R. Greenwood, vice president; Dr. Steven W. Strode, secretary; Dr. Thomas L. Eans, treasurer; and Dr. Samuel B. Welch, immediate past president.



Dr. Johnson

## Retiring Physician Honored at Reception

Dr. Stan Teeter and his wife, Maysel, greeted friends and patients during a reception in their honor at the Millard-Henry Clinic in Russellville Feb. 18. Dr. Teeter retired after 36 years of practicing medicine.

## AWARDS

### Physicians Receive Awards from AMA

Each month the American Medical Association presents the Physician's Recognition Award to those who have completed acceptable programs of continuing education.

AMA recipients for February are Dr. Sameh Ramadan A. Abul-Ezz of Little Rock, Dr. Hugh G. Donnell of Rogers, Dr. Di Hou of Little Rock, Dr. Christopher S. Johnson of Rogers, Dr. James L. Jones of Fayetteville, Dr. Anthony B. Junkin of Newport, Dr. Abdul K. Kocer of Waldron, Dr. Lance R. Lincoln of Mountain Home and Dr. Andrew J. Lueders of Rogers.

## OBITUARIES

### H.N. Faulkner, MD

Dr. H.N. Faulkner, 75, died March

7 at his home in Helena. Born in Wynne, Dr. Faulkner served in the U.S. Navy during World War II and practiced medicine in Helena for more than 33 years.

He attended the University of Southwestern Louisiana at Lafayette, La., and graduated from the University of Arkansas at Fayetteville. He graduated from UAMS in 1953 and completed his internship at Emory University-Crawford Long Hospital in Atlanta.

Dr. Faulkner was on the staff of Helena Regional Medical Center until his retirement in 1987, and served as chief of staff in 1975. He was a member of the Phillips County Medical Society, Phi Chi Medical Fraternity and Kappa Alpha Fraternity.

He is preceded in death by his father, H.N. Faulkner Sr.; his mother, Georgia Bullard Faulkner; and his sister, Wila Maxine Faulkner. He is survived by his wife, Helen Martin Faulkner; three sons, Robert N. Faulkner of Alexander, William M. Faulkner of Benton, Martin B. Faulkner and his wife, Laurie Faulkner of Dallas; one sister-in-law, Mildred M. Jones and her husband, Lloyd T. Jones of Horseshoe Bend; and one granddaughter.

#### John A. Rollow III, MD

Dr. John A. Rollow III of Bentonville died Feb. 8. Dr. Rollow was raised in Wynnewood, Okla., and served in both France and Japan during World War II. He completed his residency at Wesley Hospital in Oklahoma City and moved to Bentonville in 1948. For several years of his career, Dr. Rollow was one of only two surgeons in Benton County. He retired from his practice as a general practitioner in 1988. Throughout his career Dr. Rollow delivered more than 3,000 babies. In honor of his service to the community, a surgical wing at Bates Medical Center in Bentonville bears his name.

He is survived by his wife, Mary. ■

**CELEBRATING  
10 YEARS  
OF IMPROVING  
PHYSICIANS'  
BOTTOM-LINE**



*"Keeping the practice of  
medicine independent"*

## **PHYSICIANS MANAGEMENT SERVICES, INC.**

- Coding
- Billing
- Receivable Management & Management Consulting
- Transcription

Scott McCall & Linda Cochran • 2909 Military Road, Benton, AR 72015  
1-800-353-6165 • e-mail: pms112291@aol.com • www.physiciansmgmt.com

**The one thing missing  
is you.**



8201 Ranch Boulevard - Building B - Suite 5  
Little Rock, AR 72212 - 501-868-9959 - 800-713-0037



# Mockingbird Bay Resort on Lake Norfolk

Located in the heart of the beautiful Ozark mountains, the Mockingbird Bay Resort is often referred to by its guests as the "closest lake resort to rivers" because of its convenient location on Lake Norfolk and its proximity to crystal clear rivers.

Nestled among oaks, hickories, redbuds, dogwoods and mimosa pines, each cabin has its own deck overlooking the lake and mountains. All uniquely decorated, the cabins come equipped with everything you need for a relaxing weekend getaway, including remote control TV/VCRs, radios, microwaves, four-burner stoves with ovens, full-size refrigerators, coffee makers, toaster ovens, cookware, dinnerware and utensils.

The resort is a favorite among families because of its abundance of recreational activities for the children, including a treehouse, bonfire pit, sandbox, playground, horseshoes, tetherball and a game room complete with foosball, arcade games and more. Children and adults both love swimming in the pool or off the sun deck. And for guests who prefer a real swim beach, Sand Island, a popular public swimming spot, is located about a mile away.

In addition, the crystal clear water of Lake Norfolk provides for some excellent scuba diving. Many guests also enjoy sunbathing or jumping off of "Jordan Bluffs," spectacular, 15-foot bluffs that create a natural high dive into water 70-feet deep.

At the end of the day, resort guests can unwind and cook dinner outside on the Weber grills and have a relaxing picnic under the resort's covered pavillion.

Fishing is also a popular activity among the guests. The rivers that wind through the resort's mountains, such as the White River and the North Fork River, provide world-class fishing for Rainbow, German, Brown and Cutthroat trout, and the 30,000-acre lake is known for its striped bass, white and black bass, crappie, walleye and more. For boating enthusiasts, Mockingbird has a carpeted boat dock with nine stalls and a wide selection of rental boats, including two new pontoons, fishing boats and smaller boats. The resort also has a pedal boat for guests to enjoy free of charge.

Perfect for larger families, the resort also has a lakehouse that can accommodate up to 10 people. The 1,700-SF house has three queen beds, four twin beds and a panoramic lake view and balcony.

Nearby attractions to the resort include Blanchard Springs Caverns, the Ozark Folk Center, hiking and nature trails, restaurants, antique and craft shops, horseback riding and more. ■

Daily summer rates for the cabins range from \$73-\$143, and weekly rates range from \$435-\$855. Pets are not allowed at the resort.





# ADVERTISERS INDEX

AMS Benefits Inc. ....	409
Arkansas Business.Com .....	404
Arkansas Financial Group Inc., The .....	402
Arkansas Foundation for Medical Care .....	400
Asti, William Henry, AIA .....	415
Central Flying Service .....	417
EmCare .....	424
Farmers Insurance Group .....	423
Health Data Services .....	417
Maggio Law Firm .....	402
Mary Healey's Fine Jewelry .....	423
MedPlus Quotes .....	415
Online Technologies Inc. ....	408
Physicians Management Services Inc. ....	425
Professionals Advocate .....	Inside front cover
Pro Travel.....	425
Pulaski Bank .....	411
Residence Inn .....	403
Southwest Hospital .....	424
State Volunteer Mutual Insurance Co. ....	Back cover
St. Vincent Health System .....	408
The St. Paul .....	427
U.S. Air Force .....	403

Special Publications  
Publisher  
*Brigette Williams*

Special Publications  
Editor-in-Chief  
*Natalie Gardner*

Managing Editor  
*Shelby Brewer*

Copy Editor  
*Abigail West Jumper*

Editorial Assistant  
*Susan Van Dusen*

Sales Manager  
*Stephanie Hopkins*

Account Executive  
*Liz Earlywine*

Director of Design  
and Circulation  
*Virgeen Healey*

Production and  
Circulation  
Coordinator  
*Jeremy Henderson*

Editorial Art Director  
*Irene Forbes*

Advertising Art Director  
*Nikki Cruse*

Photographer  
*Mark Wilson*

Advertising Coordinator  
*Kristen Heldenbrand*

Marketing Assistant  
*Mitzi Tiffe*

Database Administrator  
*Andrea Martin*

Advertising Assistant  
*Greg Duszota*

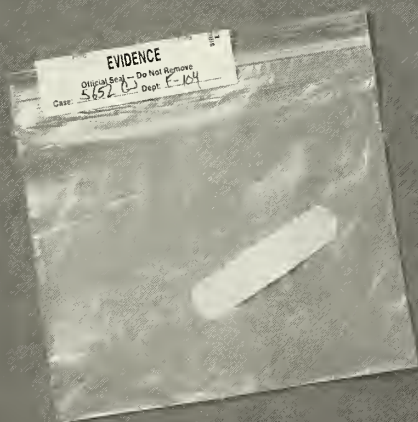
 **ARKANSAS BUSINESS  
PUBLISHING GROUP**  
www.abpg.com

Chairman & Chief Executive Officer  
*Olivia Farrell*

President and Publisher  
*Jeff Hankins*

Executive Vice President  
*Sheila Palmer*

© 2001 Arkansas Business Publishing Group



## Exhibit A:

Adhesive bandage, which plaintiff alleges defendant pulled rapidly from skin, violently tearing three hairs from plaintiff's arm, which resulted in severe shock, trauma, disfigurement, chronic debilitating pain and permanent psychological damage.

To protect your reputation, we  
take every claim seriously.

Even the most absurd claims can be damaging if they're not handled properly. Which is why the full weight of our more than 60 years of experience in medical liability insurance is brought to bear on each and every claim, no matter how frivolous that claim may appear. In fact, when appropriate, we have appealed cases all the way to the United States Supreme Court, at no additional cost to policyholders. Because you can't put a bandage on a damaged reputation.

**The St Paul**

©2000 St. Paul Fire and Marine Insurance Company  
Coverages underwritten by St. Paul Fire and Marine Insurance  
Company or another member of The St. Paul Companies  
www.stpaul.com



1999 was a Year to Regroup and Refocus, 52  
50-year Club, 56

# A

A Baseline is Necessary, 97  
A Higher Calling, 405  
A Horrible System for Everybody, 277  
Abel, Lee, 79, 331  
Abdul-Ezz, Sameh R., 424  
Ackerman, William E., III, 111, 401  
Acott, Alison A., 392  
Advocate Fatigue, 149  
Akbar, Safdar Ali, 392  
Akins, John P., 392  
Albrecht, Tammy G., 256  
Alderson, Roger Willis, 319  
Alexiou, Jerry A., 354  
Allergic Fungal Sinusitis Has Become Common, 245  
Allison, Russell B., 255  
Al-Mefty, Ossama, 422  
Al-Refai, Fareeda Ann, 256  
Amick, Roger, 422  
AMS Benefits, 383  
AMS Budget, 375  
AMS Council, 59, 368  
AMS Efforts Defend Children's Health Care, 299  
AMS Executive Vice President Report, 367  
AMS House of Delegates, 61  
AMS Medical Student Section, 384  
AMS Supports Ban on Smoking in Restaurants, 366  
AMS' Journal Has Taken on a More Sophisticated Look, 155  
AMS' Political Message Stays the Same, 153  
Anaya, Carlos, 319  
Ancalmo, Claudia M., 392  
Anderson, Charles, 287  
Angtuaco, Edward E.C., 31  
Anticoagulation Management in Mechanical Heart Valve Patients Who Undergo Dental Procedures, 128  
Araoz, C., 416  
Arkansas Behind on National Quality Improvement Indicators, 163  
Arkansas Department of Health, 387  
Arkansas Health Care Access, 385  
Arkansas Medical Foundation, 386  
Arkansas Medical Society Long-range Plan, 63  
Arkansas Patient Safety Initiative, 349  
Arkansas State Medical Board, 379  
Arkins, James Henry, 319  
Armstrong, Elizabeth, 422

Armstrong, Paul A., 422  
Arnedall, Clarence J., 256  
Arnold, James R., 255  
Arnold, Samuel H., 422  
Arora, Harendra, 422  
Arthur, David E., 392  
Ashbrooks, Darrin D., 392  
Ashley Jr., John D., 31  
Atken, Mary, 351  
Attwood, H.M., 391  
Avery, J. Kelley, 19, 97, 124, 194, 241, 277, 340, 412

# B

Babbe, Gregory J., 422  
Bacon, Lori Beth, 255  
Bailey, Amy E., 392  
Bailey, Charles W., 391  
Baker, Clark M., 68  
Baker, Robert R., 422  
Ball, Peter H., 422  
Ballard, Devon R., 135  
Banken, Joseph, 164  
Banning, Michelle S., 256  
Barber, Jeffery L., 422  
Barker, Lisa R., 392  
Barlogie, Bart., 422  
Beck II, Joseph M., 31, 149  
Beck, Jason D., 392  
Beckham Creek Cave Haven, 174  
Behind-the-Scenes Legal Work Provided AMS Members, 188  
Behrens, Bing X., 256  
Belk, Robert J., 135  
Bercher, Daniel Lance, 351  
Berry, Marion, 55  
Berry, Michael F., 256  
Bethel, John O., 414  
Bhargava, Sandeep., 422  
Bibbs, David L., 392  
Billie, James D., 255  
Bissett, Joseph., 422  
Blanchard Springs Caverns, 137  
Bledsoe, Samuel E., 392  
Bohra, Robin I., 392  
Bonner, Jimmy D., 391  
Booth, Billynda L., 392  
Bourne, David E., 424  
Bower, Charles M., 245  
Bradburn, James., 422  
Braden, Lawrence F., 205  
Bradford, Daniel., 422  
Brainard, Jay O., 391  
Braswell, Leah E., 392  
Brewer, Shelby, 302, 335, 405  
Brilliant Disguise, 79

Broach, Rolland F., 354  
Brown, Donna, 392  
Brown, Nita, 422  
Brown, Peggy J., 354  
Brown, Scott P., 392  
Brownfield, Shannon H., 256  
Browning Sr., Donald G., 319  
Brull, Sorin Jos, 66  
Brummett, Carolyn, 389  
Bryant, Derek M., 422  
Burba, Alonzo R., 346  
Burgos, Dante R., 422  
Burnette, Hugh F., 66  
Burt, William J., 422  
Burton, Frank M., 67  
Busby, James D., 391

# C

Cadle, Kimberly L., 135  
Cagle, James I., 422  
Caldwell, Karen L., 206  
Calhoun, Aris, 256  
Campanini, Maida P., 422  
Campbell, Douglas T., 422  
Campbell, Jenny, 392  
Can Business & Science Coexist in this Century, 401  
Carroll, Peter J., 391  
Carter, Sherri R., 392  
Casey, Sean P., 392  
Cassat, James E., 392  
Cawyer, John C., 392  
Chambers III, Carlton L., 62, 66, 185, 333, 377  
Chambers, Sue, 90, 299  
Chan, Patrick D., 422  
Chatelain, Stephen M., 256  
Cheney, Lori M., 422  
Citty, Jimmy C., 391  
Clark, Richard B., 283  
Cobb, Joel, 422  
Cohagan, Donald L., 255  
Coleman, Roy D., 101, 205  
Collins, Kenneth P., 101, 205  
Collins, Vera Y., 256  
Common Urologic Problems In Children: Guides To Evaluation And Referral, Part I, 420  
Congressman Champions Patients' Rights, 55  
Continuing Medical Education Committee, 389  
Cook, Jonathan M., 101, 205  
Cook, Joseph A., 255  
Cooper, Saladin A. T., 422  
Cooper, Scott S., 187

Cordell, Cari L., 392  
Cordon, Krista J., 392  
Cornell, Paul J., 67  
Cotner, James B., 256  
Councilors 2000-2001, 68  
Counts, Brian W., 392  
Cowherd, Kristy Clinton, 206  
Cowherd, Robert M., 256  
Craft, Charles W., 31  
Craig-Nunez, Rebekah, 287  
Crider, Stacy L., 392  
Criner, Owen K., 392  
Cross, Michael J., 120  
CT Scans are Helpful in Acute Abdomen Cases, 125  
Culp, William C., 232  
Czerwinski, Witold P., 422

# D

Daidone, Paul E., 256  
Daniel, Andrew D., 392  
Danner, Christopher J., 135  
Dannull, Kimberly A., 392  
Darrow, Bruce A., 256  
Davenport, David G., 422  
Davis Jr., Richard K., 256  
Davis Lee, 280  
Davis, Jeremy C., 392  
Davis, Kim., 247  
Davis, Orrin J., 256  
Davis, R. Keith, 170  
Dawson, Justin D., 256  
Day at the Capitol: Arkansas Physicians Spend Time Lobbying Local Legislators, 335  
DeGray Lake Resort, 226  
Denton, Roy E., 422  
Diacon, William L., 135  
Dickins, Robert D., 135  
Diemer, Heather Melissa, 305  
Dobbs, John C., 255  
Dominguez-Ventura, Alberto, 256  
Donnell, Hugh, 424  
Dorzab, Joe Henry, 319  
Downtown Little Rock, 289  
Drummond-Webb, Jonathan, 422  
Duke, Anton L., 255, 256  
Duncan, Lynette, 315  
Duvvuri, Uma, 422

# E

Eagan Jr., Vernon L., 422  
Eans, Thomas, 66, 424  
Eason, Delilah L., 256  
Eberle, Andrea J., 422  
Eckert, Michelle L., 422

Eckles, Laura L., 135  
 Eckles, Michael A., 422  
 Edwards, Frank D., 256  
 Eisele, Martin, 377  
 Elkins, John S., 255  
 Elliott, Robert E., 354  
 Endovascular Repair of Abdominal  
 Aortic Aneurysms, 250  
 Enhancing Patient Safety Preoperative  
 Antibiotic Prophylaxis, 418  
 Ensminger, Bobby T., 256  
 Erler, Brian S., 202  
 Evans, David M., 391, 422

## F

Family Ties, 270  
 Farooq, Etiya M., 256  
 Faulkner, H. N., 424  
 Feild, Theophilus A., 31  
 Fenton, Ronnie M., 256  
 Ferguson, Scott, 62, 66, 239  
 Ferrell, Amanda, 422  
 Fincher, Robert L., 31  
 Finck, Christine M., 256  
 Fletcher III, James W., 422  
 Florez, James P., 135  
 Floyd, Rebecca R., 101, 205  
 Foley, Regina P., 256  
 Foley, Sean M., 256  
 Formby, Thomas A., 135  
 Fort, David, 288  
 Foster, Jason, 422  
 Foundation is a 'Lifesaver' to Many  
 Uninsured, 11  
 Foxglove Bed and Breakfast, 34  
 France, James H., 422  
 Franks, Amy M., 196  
 Franks, Jason A., 288  
 Frazier, Elizabeth A., 422  
 Friedman, Charles M., 422  
 Friedman, Mark, 270  
 Frino, John, 288  
 From Bartering to Managed Care:  
 Medicine Has Drastically Changed  
 Over the Past 125 Years, 154

## G

Gaddam, Venkatarama R., 343, 422  
 Galli, William P., 422  
 Gallman, Judith M., 47, 52  
 Galloway, William W., 255  
 Garcia, Robert, 288  
 Gardner, Natalie, 11, 82, 270  
 Garner, William 'Bill', 287  
 Garrett-Shaver, Martha G., 288  
 Garrison, James S., 287  
 Gaston, Caleb O., 288  
 Gaston, John D., 422  
 Gera, Sunil, 422  
 Gershner, Ira, 422  
 Gibbons, Glenn G., 288  
 Gibson, Gunnar H., 255, 422  
 Giles, Wilbur M., 66

Ginger, John D., 255  
 Glendenning, Charles C., 288  
 Golden, William E., 170, 349, 418  
 Goldsmith, Geoffrey, 164  
 Graham, Donna M., 320  
 Grainger, Judy, 164  
 Granberry, Mark C., 128  
 Granger, Stephanie L., 422  
 Green, Russell J., 422  
 Greene, Graham F., 170  
 Greenwood, Denise R., 424  
 Guinnip, Paula M., 422  
 Gunter, Marc, 422  
 Gupta, Arun K., 422

## H

Hadi, Ehsan M., 320  
 Hallmarks of Patient Care: History,  
 Examination, Suspicion, 124  
 Hames, William M., 320  
 Handloser, Holly H., 422  
 Hanna, Kamil I., 135  
 Hannon, Martin A., 320  
 Hardin, Alvin Scott, 151  
 Harms, Sally S., 320  
 Harrell, Jr., James, 16  
 Harrington, Paul T., 320  
 Harrison, Lonnie E., 135  
 Harton, Scott, 320  
 Hashmi, Ali Madeeh, 422  
 Hatfield, David L., 416  
 Hathcock, Stephen A., 135  
 Hawawini, May, 422  
 Hawk, James M., 320  
 Hayes, Richard L., 391  
 Hayes, Sidney, 88  
 Haynes, W. Ducote, 287  
 Hays, Deborah A., 422  
 Heard, Jeanne, 255  
 Hebbar, Prabhat K., 320, 422  
 Heif, Muhannad M., 320  
 Heifner, John K., 320  
 Hendren, Michael C., 255  
 Hester, Joe D., 287  
 HIV/AIDS in Arkansas, 23, 314  
 Holt, Brent E., 320  
 Hopkins, Robert H., 307  
 Hornberger Jr., Evans Z., 319  
 Hou, Di, 424  
 House Adopts Action Plan for Future, 45  
 Hui, Anthony, 373  
 Hutchison Jr., Ernest Lee, 287

## I

Ibrahim, Hossam, 320  
 Internet Information is a Double-edged  
 Sword, 111  
 Iron Overload and the Heart, 24  
 Irvin, Jack, 319  
 Is That So?, 267  
 Is the Big City Life Good for  
 Everyone?, 189

## J

Jackson, Phillip C., 320  
 Jaderborg, Jana M., 320  
 Jarvis, Robert M., 354  
 Jazieh, Abdul Rahman, 132  
 Jetton, Christina A., 135  
 Johnson, Anthony D., 424  
 Johnson, Christopher, 424  
 Johnson, Dwight, 384  
 Johnson, Jill T., 128  
 Johnson, Melissa, 315  
 Johnson, Sandra M., 86, 287, 354  
 Jones, Edward J., 101, 205  
 Jones, James, 424  
 Jones, Karla R., 354  
 Jouett, W. Ray, 45  
 Junkin, Anthony, 424

## K

Kabani, Noor, 31  
 Kazzas, Nelly, 24  
 Keadle, William Ray, 288  
 Keller, Pat, 385  
 Kelley, Steven E., 98  
 Kellow, Amir L., 354  
 Kelsey, J.F., 288  
 Kendall, Jerry R., 232  
 Kennedy, Robert B., 31  
 Kerr, Robert L., 101, 206  
 Kilgore, Kenneth M., 101, 206  
 Kinchen, Delaney L., 354  
 Kinslow, Ivory A., 354  
 Kishan, Channarayapatna, 24  
 Knee-Jerk Docs, 185  
 Knight, Dan, 135  
 Knowles, Glen C., 101, 206  
 Knox, Michael R., 250  
 Koehler, Kevin R., 354  
 Ko enig, Albert S., 101, 206  
 Kocer, Abdul, 424  
 Kolb, David C., 135  
 Kremp, Richard E., 354  
 Krupala, James Lee, 31  
 Kubacak, Brian M., 255  
 Kula, Zbigniew, 31  
 Kyser, James, 255

## L

Laffoon, Gregory, 354  
 LaMastus, Ken, 367  
 Lamps, Christopher A., 31  
 Landrum, Samuel E., 7, 267  
 Lang, Nicholas P., 205  
 Langston, Thomas A., 31  
 Lawrence, Debra C., 354  
 Lawrence, George S., 354  
 Learn from and Respond to the Medical  
 Record, 194  
 Learning from the Experts, 47  
 Legislative Advocacy – Everyday, All  
 Day, 301  
 Lehmkuhl Rachel J., 354

Leibovich, Marvin, 410, 411  
 Lian, Fangru, 354  
 Lincoln, Lance, 424  
 Linskey, Mark Elwood, 354  
 Logan, Charles W., 205, 255  
 Long Range Planning Committee, 62,  
 377  
 Long, Eric D., 354  
 Lu, Ellen, 354  
 Lueders, Andrew, 424  
 Luzietti, Nicholas P., 354  
 Ly, Phuong C., 31  
 Lyle, Carlene W., 31

## M

Ma, Frank, 319  
 Mac Brown, Terry, 256  
 Madera, George J., 354  
 Magie, Jimmie J., 255  
 Maglothlin, Doug, 206  
 Mahdavy, Mustafa, 354  
 Making it Count: Physicians Urged to Take  
 Active Role in Political Process, 236  
 Malloy, Mark, 31  
 Maloney, Francis P., 391  
 Managed Cared Rarely Touched This  
 Physician's Life, 156  
 Managing Diabetes Mellitus, 307  
 Mancino, Michael J., 354  
 Martindale, Joseph, 386  
 Mason, James Z., 101, 206  
 Matthews, Joseph W., 187  
 Maxwell, Ralph, 205  
 May, Brett H., 354  
 McAndrew, Brian P., 354  
 McEwen, Stanley R., 172  
 McGee-Reed, Ivy V., 135  
 McKee, John, 343  
 McMinimy, Donald J., 67  
 McNellis, Emily M., 354  
 McNellis, Ryan E., 354  
 Meadors, Fred A., 250  
 Medical Education Foundation for  
 Arkansas, 377  
 Meeker, Chris A., 135  
 Membership Listing, 207  
 Merrick, Jason A., 354  
 Mhoon, John M., 135  
 Middleton, Toni L., 355  
 Milligan, Lynda B., 101, 205  
 Mirza, Mashhud Munir, 355  
 Mitchell, Katherine B., 355  
 Mitchell, Michael W., 192  
 Mockingbird Bay Resort on Lake  
 Norfolk, 426  
 Mohrmann, Harry, 132  
 Montanez, Josue, 125, 319  
 Morgan, Justin E., 355  
 Morgan, Martha K., 31  
 Moss, Mark, 355  
 Mountain Harbor Resort, 257  
 Munir, Muhammad T., 355



**N**

Nasal Meningioma: Report of One Case and Review, 416  
 Negligence or Not, 19  
 Nelson, Carl, 170  
 Nelson, Elizabeth B., 135  
 Nelson, Richard, 31  
 New Alliance President Touts Active Membership, 57  
 New Service Allows Physicians to "Connect" With Their Patients, 403  
 No Longer a Man's World: Women Continue to Move Medicine Forward, 83  
 Nokes, Steven R., 125, 135, 245, 346, 414  
 Nolen, John R., 355  
 Nominating Committee, 373  
 Norris, Elvin L., 101, 206  
 Nunnally, Robert H., 391

**O**

Ochoa Jr., Eduardo R., 355  
 Officers 2000-2001, 68  
 Older Female Inpatients in Arkansas, 315  
 Open versus Thoracoscopic Removal of Left-Sided Mid-Esophageal Leiomyoma, 247  
 Orten, Steven S., 31  
 Overacre, Robert L., 31

**P**

Padilla, Jose S., 255  
 Paperwork will Decrease with New HIPPA Regulations, 113  
 Pappas, Lila, 135, 355  
 Pappas, Paul H., 135, 355  
 Parcon, Paul J., 355  
 Partridge, Paige M., 355  
 Paslidis, Nicholas J., 170  
 Pate, Kimball B., 391  
 Paulson, Kathleen, 391  
 Paxton, Jason S., 391  
 Payne, Elisa M., 255  
 Pediatric Injuries Resulting from Use of All-Terrain Vehicles, 351  
 Peebles, Chester, 171  
 Peebles, Jody Warren, 255  
 Peterson, Hilary A., 391  
 Petty, Corwin D., 391  
 Phillips, Craig H., 392  
 Phillips, David, 247  
 Phooshooru, Vijay R., 392  
 Pitas, Grzegorz A., 135  
 Platt, Lucas O., 135  
 Pogue, Stacey A., 392  
 Politics and Medicine, 232  
 Pond Mountain Lodge and Resort, 357  
 Porterfield, James G., 392  
 Posterior Dislocation of the Shoulder is Uncommon, Hard to Diagnose, 414  
 Postoperative Care — Inattentive Approach, 412  
 Powell, Brenda, 92

Power, Robert C., 255  
 Preventing Perinatal HIV: Prenatal HIV Testing and Strategies to Reduce the Risk of Maternal-Fetal HIV Transmission, 27  
 Prince, Audra M., 392  
 Progress on the Long-Range Plan, 333  
 Prompt-Payment Rule Moves Forward, 269  
 Prosser, Robert L., 101, 206  
 Pulaski County Medical Society, 389  
 Pulmonary Hypertension in Pregnancy, 98  
 Pyron, Luke D., 392

**Q**

Quality Improvement Programs Depend on Team Work, 164

**R**

Rainwater, Melissa C., 392  
 Ramsay Jr., Rex C., 206  
 Rangaswami, Narayanswami, 287  
 Ransom, Clarence E., 391  
 Razer, Hani A., 160, 202  
 Recruiting for Rural Arkansas, 191  
 Reddy, Pramod P., 420  
 Reddy, Vijayabhasker, 32  
 Redman, Anna, 94  
 Redman, John F., 420  
 Reported Cases of Selected Diseases, 282  
 Revard, Ronald E., 255  
 Ridgecrest Resort on Bull Shoals Lake, 321  
 Right Ventricular Infarction, 160  
 Rimawi, Asem, 343  
 Robertson, John A., 392  
 Robinson, Martin J., 392  
 Rodgers, Charles H., 135  
 Rodgers, Jr., Porter, 319  
 Rodgers, Michelle L., 392  
 Rogers, Rachel M., 391  
 Rollow, III, John A., 424  
 Ross, R.W., 170  
 Rothenberger, Andrea, 315  
 Rowe, Tracy L., 391  
 Rozas, David R., 101, 206  
 Rural Physician Represents New Face of Medicine, 157  
 Rusher, A.H., 247

**S**

Saccante, Michael, 27  
 Sanchez, Nena, 418  
 Schechter, Ron D., 391  
 Scheer, Blake G., 311  
 Schlesinger, Scott M., 346  
 Schoettle, Glenn P., 66  
 Schumann, Gerald M., 171  
 Scott, Jane, 255  
 Scurlock, William, 391  
 Serial Troponin I Measurements Detect Recurrent Myocardial Infarction After Initial Acute Myocardial Infarction, 202  
 Shah, Shailesh R., 391

Shock, John P., 170  
 Short, Walter, 391  
 Sitz, Karl V., 311  
 Sitzes, David A., 391  
 Sloan, Fredric J., 101  
 Smith, Carl V., 31  
 Smith, Christy L., 83, 115, 123, 154, 157, 187, 236  
 Smith, Eugene S., 98, 128, 160, 196, 280, 343  
 Smith, Jr., Floyd A., 287  
 Smith, Lynette, 391  
 Smith, Melanie, 32  
 Smith, Steven O., 32  
 Smith, Todd P., 391  
 Snyder, Vic, 135  
 Sosebee, William S., 32  
 Sotomayor, Edgar A., 391  
 Spradlin, Timothy L., 255  
 Srinivasan, Pattana, 32  
 Staley, Kelly, 351  
 Starnes, Harry D., 255  
 State Senator Awarded National AMA Award, 123  
 Stecker, Rheeta M., 255  
 Stewart, R. Todd, 32  
 Stewart, Tracey D., 245  
 Stockburger, John S., 135  
 Stolz, Gerald, 51, 255, 383  
 Storeygard, Alan, 135  
 Stough, Dowling B., 287  
 Stout, Michael D., 32  
 Strode, Steven, 287, 389, 424  
 Stubblefield, William S., 135  
 Sturmer, William O., 255  
 Submerging Technology: Hyperbaric Medicine, 7  
 Sullivan, Sarah L., 391  
 Suspected Insulin Anaphylaxis and Literature Review, 311  
 Swarup, Sachin, 32

**T**

Tacoronti, Rudolph V., 32  
 Taking the Helm, 51  
 Talley, David, 202  
 Tanyard Springs, 393  
 Tarpley, Jon A., 135  
 Teeter, Stan, 424  
 The AMS Health Benefit Plan — A Eulogy, 81  
 The Big Easy, 115  
 The Gospel According to 'Calvin and Hobbes', 331  
 The Langston Collection, 283  
 The Reality of Mammography Utilization in the State of Arkansas, 132  
 The Role of Amiodarone in the Management of Patients with Cardiac Arrest, 196  
 The Same Lesson Again and Again, 340  
 Thomas, Audra R., 128  
 Thomas, Joanna, 315

Thomson, Robert C., 255  
 Thoracic Aortic Aneurysm Revisited, 343  
 To Merge or Not to Merge?, 302  
 Tobacco Cessation, 280  
 Trauma — What Were the Facts?, 241  
 Triplett, Sheila B., 391  
 Tullis, Joe M., 255  
 Turner, Frederick C., 354  
 Turner, Lori W., 351  
 Tutt, Richard D., 255, 392  
 Tzuoh Hong, Michael, 320

**U**

Use of Diffusion-Weighted Images, 346

**V**

Valdes, Raymond P., 392  
 Van Asche, Christopher, 135  
 Van Scoy, Sara Elsie, 392  
 Van Scoy, William R., 392  
 Vasudevan, Kanaka, 338  
 Vasudevan, P., 338  
 Vice President Pushes for Patients' Bill of Rights, 82

**W**

Wagoner, Charles H., 32  
 Waheed, Imran, 392  
 Walker, Ronald, 414  
 Wallace, Oliver, 101  
 Waller, John, 392  
 Ward, Harry, 101  
 Ward, Kristin, 164  
 Ward-Jones, Susan, 84  
 Waters, James D., 32  
 Watterson, Krista Sue, 196  
 Weber, Cynthia W., 57, 135  
 Weber, James R., 135  
 Welch, Samuel B., 424  
 Wells, Britton C., 135  
 West Nile Fever in the United States, 200  
 West, Donna, 418  
 What Have You Done For Yourself Lately?, 235  
 White, Bruce A., 255  
 White, Mark, 416  
 Whitely, Andre B., 205  
 Wiggins, L., 247  
 Wilkins, Jr., Walter J., 101  
 Williams, Dwight M., 274  
 Wills, Paul I., 255  
 Wilson, I. Dodd, 101, 135  
 Wilson, Morton C., 255  
 Wish You Had Been There, 9  
 Worrell, Jr., Aubrey M., 136  
 Wroten, David., 9, 45, 81, 113, 188, 235, 269, 301, 366, 403

**Y**

Young, Michael C., 385

**Z**

Zeno, Z. Lynn, 153

9802 -

# How do you reach 4,300 physicians in Arkansas?

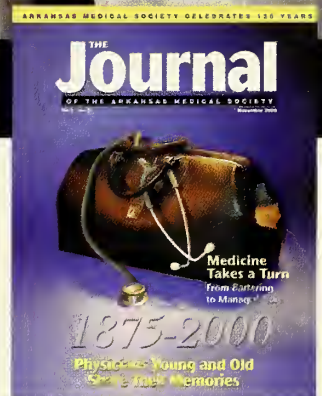


## Advertise in *The Journal*.

Each month, 4,300 physicians across the state read the Arkansas Medical Society's monthly publication, *The Journal*, for the latest information affecting Arkansas' medical community.

*The Journal* is the ideal opportunity to showcase your products and services to this affluent, professional market.

*The Journal* is a must to reach this active medical market. For more information, call Stephanie Hopkins at (501) 372-2816 or e-mail [stephanie@abpg.com](mailto:stephanie@abpg.com).



**THE Journal**  
OF THE ARKANSAS MEDICAL SOCIETY







Preparing for the worst is still the best way to avoid it.

The funny thing about rainy days, and certain other catastrophies, is that the better prepared you are, the less likely it is that anything will ever happen. So it is with the physicians who look to SVMIC for our unrivaled expertise in risk management. Or, in the unhappy event of a cloudburst, our unparalleled support in the courtroom. With a quarter century of experience as malpractice insurers, we are qualified like no one else could be, when it comes to providing the shelter you'll need, should the worst case scenario ever become more than an unpleasant possibility.



State Volunteer  
Mutual Insurance  
Company

For more information, contact Thad DeHart or Susan Decareaux • P.O. Box 1065 Brentwood, TN 37024-1065  
e-mail: [svmic@svmic.com](mailto:svmic@svmic.com) • Web Site: [www.svmic.com](http://www.svmic.com) • 1-800-342-2239 • (615) 377-1999







NOT TO CIRCULATE

NOT TO CIRCULATE



